No. 97-1868-CFX Title: UNUM Life Insurance Company of America, Petitioner
v.
John E. Ward

Docketed:
May 20, 1998

Court: United States Court of Appeals for the Ninth Circuit

See also:
97-1867

Entry	Date	Proceedings and Orders
	May 20 1998	Petition for writ of certiorari filed. (Response due July 20, 1998)
	Jun 9 1998	Order extending time to file response to petition until July 20, 1998.
	Jul 10 1998	Motion of Standard Insurance Company for leave to file a brief as amicus curiae filed.
	Jul 20 1998	Brief of respondent John E. Ward in opposition filed.
	Jul 20 1998	Motion of Association of California Life and Health Ins. Companies for leave to file a brief as amicus curiae filed.
	Jul 20 1998	Motion of American Council of Life Insurance, et al. for leave to file a brief as amici curiae filed.
	Aug 3 1998	Reply brief of petitioner UNUM Life Insurance Company of America filed.
	Aug 5 1998	DISTRIBUTED. September 28, 1998
	Oct 5 1998	REDISTRIBUTED. October 9, 1998
	Oct 13 1998	Motion of Standard Insurance Company for leave to file a brief as amicus curiae GRANTED.
	Oct 13 1998	Motion of Association of California Life and Health Ins. Companies for leave to file a brief as amicus curiae GRANTED.
	Oct 13 1998	Motion of American Council of Life Insurance, et al. for leave to file a brief as amici curiae GRANTED.
	Oct 13 1998	Petition GRANTED. SET FOR ARGUMENT February 24, 1999. **********
	Nov 25 1998	Order extending time to file brief of petitioner on the merits until December 2, 1998.
	Nov 27 1998	Brief amicus curiae of United States filed.
	Nov 27 1998	Joint appendix filed.
	Nov 30 1998	Brief amicus curiae of Assn. of California Life and Health Insurance Companies filed.
	Dec 2 1998	Brief of petitioner Unum Life Insurance Company of America filed.
	Dec 2 1998	Brief amicus curiae of Business Roundtable filed.
	Dec 2 1998	Brief amici curiae of American Council of Life Insurance, et al. filed.
	Dec 2 1998	Brief amici curiae of Association of Private Pension and Welfare Plans, et al. filed.
	Dec 8 1998	Order extending time to file brief of respondent on the merits until January 4, 1999.
	Dec 10 1998	Order further extending time to file brief of respondent on the merits until January 8, 1999.

No. 97-1868-CFX

Entry	Date	Proceedings and Orders
	Jan 7 1999	Brief amicus curiae of National Employment Lawyers Association filed.
	Jan 8 1999	Brief amicus curiae of National Association of Insurance Commissioners filed.
	Jan 8 1999	Brief amici curiae of Texas, et al. filed.
	Jan 8 1999	Brief amicus curiae of American Association of Retired Persons filed.
	Jan 8 1999	Brief amici curiae of Council of State Governments, et al. filed.
	Jan 8 1999	Brief of respondent John E. Ward filed.
	Jan 12 1999	Motion of Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument filed.
	Jan 13 1999	CIRCULATED.
	Jan 25 1999	Motion of Solicitor General for leave to participate in oral argument as amicus curiae and for divided argument GRANTED.
	Feb 10 1999	Reply brief of petitioner UNUM Life Insurance Company of America filed.
	Feb 17 1999	Supplemental brief of respondent John E. Ward filed.
	Feb 22 1999	Record filed.
	Feb 22 1999	Supplemental brief of petitioner filed.
	Feb 24 1999	ARGUED.

Supreme Court, U.S.
FILED

No. 97-1868 MAY 20 1998

OFFICE OF THE CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Whether, in an opinion expressly acknowledging a circuit conflict—indeed, one affecting eight circuits—the Ninth Circuit erred in holding that a state law (the "notice-prejudice" rule) need not satisfy all three McCarran-Ferguson Act criteria for the "business of insurance" in order to be saved from preemption under ERISA.

2. Whether the Ninth Circuit—contrary to the law in nine other circuits—erred in holding that a state law survives ERISA preemption even though it conflicts not only with ERISA's requirement that fiduciaries administer all plans "in accordance with" their written terms, but also with ERISA's exclusive civil enforcement scheme by expanding the remedies beyond those expressly provided for in the Act.

3. Whether—also contrary to the law in other circuits—the Ninth Circuit erred in holding that ERISA does not preempt a state law (one incorporating agency principles) even though it conflicts not only with ERISA's regulation of initial claims filing and processing and its allocation of fiduciary responsibility, but also with the remedies provided in its exclusive civil enforcement scheme.

PARTIES

The petitioner is UNUM Life Insurance Company of America ("UNUM"). The respondent is John E. Ward.

Pursuant to Rule 29.6 of the Rules of the Supreme Court, petitioner states that UNUM Corporation is the parent of UNUM. UNUM Corporation has two non-wholly owned subsidiaries, Boston Compania Argentina de Seguros S.A. and UNUM Delaware Company. UNUM Life Insurance Company of America has one non-wholly owned subsidiary, SP Administrator, LLC.

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IN THE

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OCTOBER TERM, 1997

No. ———

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v

JOHN E. WARD,
Respondent.

Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

---

PETITION FOR A WRIT OF CERTIORARI

Petitioner, UNUM Life Insurance Company of America ("UNUM"), respectfully submits that a writ of certiorari should issue to review the judgment and opinion of the United States Court of Appeals for the Ninth Circuit in this case.

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 135 F.3d 1276 (9th Cir. 1998), and is reprinted in the Appendix ("App.") at 1a to 25a. The Court of Appeals' denial of UNUM's petition for rehearing, with a suggestion for rehearing en banc, entered on March 23, 1998, is unreported. App. at 26a. The District Court's opinion granting summary judgment to UNUM (App. at 27a to 33a) is unreported.

JURISDICTION

The Court of Appeals' order denying UNUM's petition for rehearing, with a suggestion for rehearing en banc, was entered on March 23, 1998. This petition is being timely filed within 90 days of that date. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves the statutes and regulations set forth at App. 99a to 108a.

STATEMENT OF THE CASE

A. Factual Background

In February of 1983, UNUM issued a group long-term disability insurance policy to fund an employee welfare benefit plan (the "Plan") sponsored by Management Analysis Company ("MAC"), an employer with multi-state operations. App. at 59a, 47a. Respondent John Ward worked for MAC in California, serving as its President and Chief Executive Officer ("CEO"). App. at 2a, 78a, 83a to 86a. The Plan is covered by the Employee Retirement Income Security Act ("ERISA"). App. at 2a. While the employer-sponsor served as Plan Administrator,[1] UNUM performed not only the Plan's initial claims-handling and payment functions, but also the fiduciary review procedure for denied claims required by ERISA.[2] The Plan explicitly stated that the employer serves as Plan Administrator and acts on its own behalf or as an agent for its employees, and not as UNUM's agent. App. at 44a.

A participant in the Plan since its inception in 1983, Ward concedes that he was aware of the Plan and had received from MAC in 1983 a certificate of coverage containing the Plan's summary plan description. App. at 2a. This certificate described not only the Plan's benefits and requirements for eligibility and participation, but also the procedures and deadlines Ward had to follow in submitting claims to UNUM. App. at 41a to 43a. As CEO, Ward met annually with the company's human resources division to review MAC's insurance plans, including the Plan, and five months before his resignation he attended a company-wide meeting relating to MAC's benefits at which a UNUM representative gave a summary of the Plan's benefits. App. at 32a to 33a.

Ward served as President and CEO of MAC until May 8, 1992, when he resigned upon the Board of Directors' request over financial concerns about a particular company project. App. at 27a. Ward asserts that by May of 1992, he had begun to experience a disabling condition, and that by December of that year he had received a medical diagnosis of his diabetes and alleged disability. In early 1993, he applied for and received state disability benefits, and alleges that he contacted MAC's human resources division to discuss extension of his COBRA continuation insurance. In July of 1993, he received a Social Security Determination that he was eligible for Social Security benefits, a copy of which he sent to the human resources division. App. at 28a.

Ward, however, did not submit a claim for plan benefits until April, 1994. UNUM received Ward's notice and proof of claim form on April 11, 1994, nearly two years after the onset of his claimed disability. This was UNUM's first actual notice of the claimed disability. App. at 38a.

The Plan's written notice and proof of claim provisions required a participant to submit to UNUM written notice of claim for plan benefits within 30 days of the date a disability starts, if possible, and a written proof of claim, at the latest, one year and 180 days after the onset of disability. App. at 42a to 43a. Ward's notice of claim

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[1] App. at 13a; ERISA § 3(16)(A), (B), 29 U.S.C. § 1002(16)(A), (B).

[2] App. at 39a; ERISA § 503, 29 U.S.C. § 1133.

was untimely by nearly 15 months, and his written proof of claim was submitted nearly five months after the Plan's last deadline. App. at 5a. Accordingly, no benefits were "due" under the Plan's written terms.

Ward asserted, however, that he did not know about the "availability" of the Plan until April of 1994, when he claims he discovered his certificate of coverage among papers in his safety deposit box. App. at 3a. Ward also contended that MAC should be considered the "agent" of UNUM notwithstanding that MAC was the Plan Administrator and the Plan expressly stated that MAC was not UNUM's agent; that MAC purportedly knew he was "disabled" by 1992 or 1993; and that this claimed knowledge should not only be imputed to UNUM but also free him from the Plan's written requirements of timely written notice and proof of claim to UNUM. App. at 7a to 8a.

After reviewing Ward's claim for plan benefits and supporting materials, UNUM determined that he was ineligible because he did not submit his written claim within the Plan's written time limits. UNUM notified him of its decision in April of 1994; he, in turn, requested a review. App. at 29a, 90a to 95a. In the ERISA-required fiduciary review procedure for denied claims, UNUM upheld the decision to deny plan benefits. App. at 96a to 98a.

B. The District Court Proceeding

On September 15, 1995, Ward filed sut against UNUM and the Plan in United States District Court for the Southern District of California to recover plan benefits under ERISA. App. at 77a to 98a. He did not assert a claim against MAC. On August 8, 1995, the District Court granted UNUM and the Plan summary judgment under ERISA. App. at 27a to 33a. The District Court held that the Plan's written proof of claim provision required that proof of claim be filed with UNUM in writing within one year and 180 days after the onset of disability, and that Ward failed to comply with this provision. Additionally,

the District Court rejected Ward's arguments that California's common-law *"Elfstrom"* rule [3] survived ERISA preemption and governed the payment of plan benefits. App. at 30a to 33a. The *"Elfstrom"* rule, if applicable, would make MAC the "agent" of UNUM, imputing to UNUM any knowledge which the employer had of Ward's disability and, also in Ward's view, requiring the payment of benefits regardless of the fact that the Plan's written proof of claim provision had been violated. Ward appealed.

C. The Ninth Circuit's Decision

On appeal of the summary judgment, the Ninth Circuit reversed the District Court's decision on two grounds, the *"Elfstrom"* rule and California's "notice-prejudice" rule. The Ninth Circuit's holdings on both rules warrant a plenary review.

The Ninth Circuit agreed that Ward failed to satisfy the Plan's unambiguous written proof of claim provision. It then addressed Ward's contention that the "notice-prejudice" rule would preclude UNUM—the claims review fiduciary—from upholding the claim denial unless it could establish "actual prejudice" from the failure to comply with the proof of claim provision. The Ninth Circuit held that California's common-law "notice-prejudice" rule was within the scope of ERISA preemption as a state law which "related to" an employee benefit plan. ERISA § 514(a), 29 U.S.C. § 1144(a). It held, however, that the rule was "saved" from ERISA's preemption because it was a state law regulating insurance, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), and therefore could be applied to Ward's claim for plan benefits. In so doing, the Ninth Circuit followed its earlier decision in *Cisneros v. UNUM Life Ins. Co. of America*, 134 F.3d 939 (9th Cir. 1998) (*"Cisneros"*), App. at 5a

[3] The rule takes its name from *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503, 505 (1967).

to 6a, a case in which a petition for writ of certiorari is being filed concurrently herewith.[4]

In *Cisneros*, the Ninth Circuit had concluded that under *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-50 (1987), ERISA's "saving" clause may be applicable only if the state law clears two hurdles: a common-sense test that the law be "specifically directed" at the insurance industry, and the "saving" clause requirement that the law must "regulate insurance." 134 F.3d at 944-945. To determine whether the state law regulated insurance, the Court analyzed whether it satisfies the three McCarran-Ferguson Act criteria for the "*business of insurance.*" *Id.* at 945. Under these criteria as articulated by the Supreme Court, the state law must first have the effect of transferring or spreading the policyholder's risk of loss to the insurer, "an indispensable characteristic of insurance." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-212 (1979). Second, the state law must be an integral part of the insurance policy relationship between insurer and insured. Third, it must be limited to entities within the insurance industry. *Metropolitan Life*, 471 U.S. at 743; *Pilot Life*, 481 U.S. at 48-50. Additionally, to avoid a conflicts-preemption bar, the state law—even if it otherwise satisfies the "saving" clause—must not conflict with one of ERISA's substantive provisions, including its exclusive civil enforcement scheme. *Pilot Life*, 481 U.S. at 51-57.

In *Cisneros*, the Ninth Circuit found that California's "notice-prejudice" rule did *not* transfer or spread the policyholder's risk of loss to the insurer, and thus failed to satisfy the first McCarran-Ferguson criterion. Finding that the rule satisfied the last two criteria, the court then held that ERISA's "saving" clause would preserve a state common-law rule even though it did *not* satisfy all three criteria. 134 F.3d at 945-946. The *Cisneros* court ex-

[4] Respondent has been provided a copy of the petition in the *Cisneros* case.

pressly *acknowledged* that its ERISA "saving" clause holding conflicted with two decisions by the Fifth Circuit, *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.), *cert. denied*, 117 S.Ct. 386 (1996), and *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993). It stated: "We recognize that the Fifth Circuit has held that all three of the McCarran-Ferguson factors must be satisfied . . . . We . . . disagree." 134 F.3d at 946.

The *Cisneros* court also rejected UNUM's arguments, based on *Pilot Life*, 481 U.S. at 51-57, that the "notice-prejudice" rule should nevertheless be preempted under conflicts-preemption because it conflicted with a number of ERISA's key substantive provisions. UNUM pointed out that the rule would require the payment of plan benefits under circumstances where payment is barred not only by the Plan's written terms, but also by ERISA's fiduciary responsibility provisions requiring that plans must be administered "in accordance with" their written terms, and its exclusive civil enforcement scheme allowing suit for benefits only if "due" under those terms. ERISA §§ 404(a)(1)(D), 502(a)(1)(B), 29 U.S.C. §§ 1104(a)(1)(D), 1132(a)(1)(B). UNUM also pointed out that the *Cisneros* holding would result in situations where a claim would be granted or denied depending on which state's law applied. The Ninth Circuit acknoweldged a direct conflict between the "notice-prejudice" rule and ERISA, conceding that the rule caused *"a plan's written terms [to be] altered,"* caused *"complications and extra burdens" on* plan administration, and made the plan *"more difficult to administer."* Furthermore, it acknowledged that the rule *"differ[ed] markedly" in various states.* 134 F.3d at 947 (emphasis added). Nevertheless, the court rejected UNUM's argument that ERISA preempted the "notice-prejudice" rule.

In addition to adopting the "notice-prejudice" rule, the *Ward* court held that ERISA did not preempt California's

common-law "*Elfstrom*" *rule*[5] under which the employer, as administrator of a group insurance plan, is deemed the "agent" of the insurer and its knowledge is imputed to the insurer. *Ward* thus allowed two state law rules to penetrate ERISA's regulatory sphere, in contrast to *Cisneros*. Similarly to the "notice-prejudice" rule, the "*Elfstrom*" rule would require the payment of plan benefits under circumstances where payment is barred both by the Plan's written terms and ERISA's fiduciary responsibility and civil enforcement provisions. The Ninth Circuit nevertheless held that the rule did not "relate to" an ERISA plan within the meaning of ERISA's preemption clause in § 514(a). It based this extraordinary holding on *Turrill v. Life Ins. Co. of North America*, 753 F.2d 1322 (5th Cir. 1985), which *preceded* this Court's 1987 landmark decision in *Pilot Life, supra*. App. at 16a to 20a. The Ninth Circuit inferred that *Turrill*, a 1985 diversity jurisdiction case, supported a holding of no ERISA preemption because the Fifth Circuit had discussed state law agency theory without, as the Ninth Circuit put it, "even hint[ing] that state agency law is somehow preempted by ERISA." App. at 18a. This is hardly surprising, given that prior to *Pilot Life* the lower courts, including the Fifth Circuit, uniformly—but incorrectly—held that ERISA did *not* preempt such claims. *See, e.g., Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311 (5th Cir. 1985), decided by the same three judge panel as *Turrill, reversed by Pilot Life, supra. Pilot Life* in 1987 held that state common-law actions involving claims processing and the failure to pay benefits under an insured ERISA plan obviously "relate to" the plan because they have " 'a connection with or reference to such a plan.' " It therefore held that ERISA preempted these claims both through the preemption clause in §514(a) and through the exclusivity of its civil enforcement scheme in § 502(a). 481 U.S. at 47-48, 52-57. It was on this impliedly overruled and discredited Fifth Circuit authority that the Ninth Circuit relied in adopting state agency law in a suit for plan benefits.

[5] *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503, 505 (1967).

REASONS FOR GRANTING THE WRIT

I. THE NINTH CIRCUIT'S ERISA PREEMPTION DECISION CONFLICTS DIRECTLY WITH HOLDINGS IN THE THIRD, FIFTH, SEVENTH, EIGHTH, TENTH AND ELEVENTH CIRCUITS.

Once again, the Ninth Circuit has brought itself sharply into conflict with other Circuits on important federal issues which require unformity nationwide. The ERISA preemption decision on the "notice-prejudice" rule in *Ward* and *Cisneros* creates an acknowledged, direct conflict among holdings in the Circuits which only this Court can resolve. The Ninth Circuit's holding has engendered a similar holding in the Sixth Circuit but squarely conflicts with the holdings of the Fifth Circuit, which require a state law to satisfy *all three* of the McCarran-Ferguson Act factors for the "business of insurance" in order to be "saved" from ERISA preemption. *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.), *cert. denied*, 117 S.Ct. 387 (1996); *Tingle v. Pacific Mut. Ins. Co.* 996 F.2d 105, 108 (5th Cir. 1993). The *Cisneros* decision acknowledged this direct conflict. 134 F.3d at 946. In deed, the conflict is even more widespread as shown by *Tingle's* observation that "[t]he Eleventh, Sixth, Tenth and Eighth Circuits have all held that a statute's failure to satisfy one or more of the *Metropolitan Life* factors excludes it from the ERISA saving insurance clause." 996 F.2d at 110. Most recently in *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 940 (6th Cir. 1997), the Sixth Circuit acknowledged the widening Circuit conflict as to whether all three McCarran-Ferguson factors are required, holding that "no single one is dispositive." It followed *Cisneros* and provided a *but see* reference to the Fifth Circuit's *CIGNA* decision.

The Ninth Circuit's holding that the "saving" clause does not require satisfaction of the first prong of the McCarran-Ferguson test—the actual spreading or transfer of the risk of loss—further conflicts with the holdings of the Third, Seventh, Eighth, Tenth and Eleventh Cir-

cuits, all of which have uniformly ruled that state laws which fail to spread or transfer an insurance policyholder's risk, an "indispensable characteristic of insurance," *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-213 (1979), are not saved from preemption by ERISA § 514(b)(2)(A).[6]

The Ninth Circuit's preemption decision not only destroys the national uniformity of law in plan administration that is one of ERISA's chief goals, but also causes a Circuit split that is certain to widen in the future and encompass additional state law rules. This Court need look no further than two companion cases involving petitioner UNUM for a sampling of what the Ninth Circuit has in store for ERISA preemption law and ERISA plan sponsors. *See Cisneros*, petition for a writ of certiorari filed concurrently herewith (the same "notice-prejudice" rule at issue herein); *Williams v. UNUM Life Ins. Co.*, 113 F.3d 1108, 1113 (9th Cir. 1997) (California's "rolling accrual" proof of loss provision (each monthly failure to pay benefits constitutes a new cause of action) may void an ERISA plan's limitation of actions provision). The Ninth Circuit's reasoning in both of those cases is the same as its reasoning in the present case. It was because of the significant consequences the Ninth and Sixth Circuits' new preemption holdings will have on

[6] *Insurance Bd. v. Muir*, 819 F.2d 408, 412 (3d Cir. 1987) (state law which does not affect transfer of risk or satisfy any other McCarran-Ferguson Act factor is preempted); *Tingle*, 996 F.2d at 108 (state law which fails to transfer risk is preempted); *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 428-30 (6th Cir. 1989) (state law which fails to transfer risk or satisfy third factor is preempted); *DeBruyne v. Equitable Life Assurance Soc.*, 920 F.2d 457, 468-70 (7th Cir. 1990) (same); *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153-54 (8th Cir. 1990) (state law which fails to transfer risk is preempted); *cert. denied*, 501 U.S. 1238 (1991); *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 455-56 (10th Cir. 1989) (state law which fails to transfer risk or satisfy second factor is preempted); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467, 1468-69 (11th Cir. 1988) (same).

insured plans that a petition for a writ of certiorari has been filed concurrently in the *Cisneros* case.

This acknowledged Circuit conflict on a significant ERISA preemption issue is alone sufficient ground for this Court's review.

II. THE NINTH CIRCUIT'S PREEMPTION DECISION CONFLICTS DIRECTLY WITH NINE OTHER CIRCUITS WHICH ENFORCE WRITTEN PLAN PROVISIONS SUCH AS NOTICE REQUIREMENTS.

Still another reason supports the granting of a writ of certiorari. In a direct clash with ERISA's plain language and decisions from nine other Circuits, the Ninth Circuit's adoption of the "notice-prejudice" and *"Elfstrom"* rules will allow state common-law claims in one or more states to *void* a number of ERISA's key substantive provisions and prohibit written plan notice requirements permitted by ERISA. In so doing, the decision not only destroys ERISA's goals of a *"uniform body of benefit law"* and the *"nationally uniform administration"* of plans, *National Conf. of Blue Cross-Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 657 (1996) (citation omitted) (emphasis added) (*"Travelers"*), but also overlooks significant constraints which ERISA, this Court and the other Circuits have imposed on the adoption of state common-law principles in the employee benefit field.

As set forth in more detail at pages 8 to 14 of the petition for a writ of certiorari in *Cisneros*, ERISA is a " 'comprehensive and reticulated statute,' the product of a decade of congressional study of the nation's private employee benefit system." *Mertens v. Hewitt Associates*, 508 U.S. 248, 251 (1993) (citation omitted). One of ERISA's purposes is to avoid a "multiplicity of regulation", a " 'conflict in . . . law' " and ' " conflicting directives' " between federal and state regulatory systems. *Travelers*, 514 U.S. at 656-657. ERISA contains a preemption clause in § 514(a) which, among other effects,

preempts state laws that "mandate[] employee benefit structures or their administration," "prohibit" what is "permitted" by federal law, "preclude uniform administrative practice," or provide "alternate enforcement mechanisms." 29 U.S.C. § 1144(a); 514 U.S. at 657-658, 660. In striking a balance between competing federal and state interests, Congress made the administration of both insured and self-funded ERISA plans, including claims processing, " 'exclusively a federal concern.' " *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987) (citation omitted). Congress intended to "minimize[] the need for interstate employers to administer their plans differently in each State in which they have employees." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983).

To ensure uniformity of law, Congress enacted a broad array of national, uniform fiduciary standards to govern the administration of both self-funded and insured ERISA plans. ERISA §§ 401-414, 503, 29 U.S.C. §§ 1101-1114, 1133. Indeed, Congress codified federal "trust" principles in ERISA not merely to ensure "*uniformity*," but also to ensure that certain "plans, such as insured plans, which do not use the trust form as their mode of funding," would be subject to the same exacting standards.[7]

Additionally, one "of ERISA's purposes is to protect the financial integrity of pension and welfare plans by confining benefits to the terms of the plan as written." *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992) (Posner, J.) ERISA's "written plan instrument" rule, one of ERISA's "core functional requirements," *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 78, 84 (1995), assists in ensuring the nationally uniform administration of plans. It requires that all plans—self funded and insured alike—be in writing and be administered by fiduciaries "*in accordance with*" their

[7] H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973) 2 Legislative History of the Employee Retirement Income Security Act at 2359 (emphasis added).

written terms to the extent not inconsistent with ERISA. ERISA §§ 401(a), (b), 404(a)(1)(D), 29 U.S.C. §§ 1102(a), (b), 1104(a)(1)(D) (emphasis added).[8] Moreover, ERISA's exclusive civil enforcement provisions ensure the same goals, authorizing suit *only* if benefits are "due" under those written terms. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B); *Pilot Life*, 481 U.S. at 52-57.

Apart from the Ninth Circuit, the Courts of Appeals have consistently carried forward ERISA's goal of a uniform national body of law to govern plan administration by holding that ERISA preempts state common-law "notice" rules or "notice" statutes, or state law agency rules, all of which vary from state to state. The decisions' rationale is that these state laws not only "relate to" ERISA plans, but also conflict either with the sponsor's freedom of plan design or the Act's comprehensive regulatory scheme. *See, e.g., Nazay v. Miller*, 949 F.2d 1323, 1336-1337 (3d Cir. 1991) (ERISA preempts "notice-prejudice" rule with respect to self-funded plan); *Howard v. Gleason Corp.*, 910 F.2d 1154, 1157-1158 (2d Cir. 1990) (ERISA preempts state statute requiring a terminated employee be notified of insurance conversion options); *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 571 (11th Cir.) (ERISA preempts state statute governing notice to insured of termination of coverage), *cert. denied*, 513 U.S. 808 (1994); *Doe v. Blue Cross & Blue Shield United*, 112 F.3d 869, 874-875 (7th Cir. 1997) (ERISA plan's internal limitations period controls over state statute); *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-1490 (7th Cir. 1996) (ERISA preempts state law agency claims related to a denial of plan benefits).

[8] The plan documents, which include the "contract or other instruments under which the plan is established or operated," encompass group insurance policies. ERISA § 104(a)(1), (b)(2); *see e.g., Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277, 280 (11th Cir. 1987); *Roe v. General American Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983).

Furthermore, other Circuits have consistently held that ERISA precludes the use of any state or federal doctrines —similar to the two state law rules involved here—that would cause a departure from the plan's unambiguous written terms, or any of ERISA's carefully-drawn statutory provisions which ensure uniformity in plan administration. *See, e.g., Nachwalter v. Christie*, 805 F.2d 956, 960 (11th Cir. 1986) ("federal courts may not use state common law to re-write a federal statute"); *Member Services Life Ins. Co. v. Amer. National Bank and Trust Co.*, 130 F.3d 950, 957-958 (10th Cir. 1997) (courts cannot "rewrite [ERISA] to satisfy [their] proclivities"); *Pohl*, 956 F.2d at 128 (ERISA "confin[es] benefits to the terms of the plan as written"); *Hunt v. Hawthorne Associates, Inc.*, 119 F.3d 888, 891 (11th Cir. 1997) ("[t]he cornerstone of an ERISA plan is the written instrument"); *Edwards v. Great-West Life Assur. Co.*, 20 F.3d 748, 750 (7th Cir. 1994) (courts cannot "rewrit[e] the plan"); *Burnham v. Guardian Life Ins. Co.*, 873 F.2d 486, 490 (1st Cir. 1989) (same); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 56, 59 (4th Cir. 1992) (same), *cert. denied*, 506 U.S. 1081 (1993); *Boyer v. Douglas Components Corp.*, 986 F.2d 999, 1005 (6th Cir. 1993) (same); *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1295-1296 (5th Cir. 1989) (same).

The Ninth Circuit's decision on the "notice-prejudice" and "*Elfstrom*" rules not only directly conflicts with other Circuits, but also will spur additional litigation across the country as plan participants whose claims would be barred under the provisions of ERISA seek refuge in the more generous provisions of state law. If one or two judicial revisions of ERISA's text governing fiduciary duties and civil enforcement are appropriate through artful but erroneous readings of the preemption and "saving" clauses, plaintiffs and the lower courts will ask, why not twenty? If twenty, why not two hundred? This departure from the national uniformity of law required by ERISA, the chaos in plan administration and the increased litigation and

transaction costs will only lead plan sponsors to a reduction or elimination of benefits, *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 13 (1987), all in conflict with the "public interest in encouraging the formation of employee benefit plans," *Pilot Life*, 481 U.S. at 54.

As explained in more detail at pages 12-14 of the petition in *Cisneros*, the Ninth Circuit's decision frustrates yet another principle central to ERISA's statutory scheme—the orderly internal resolution of benefit disputes as a prerequisite to filing suit under the Act's civil enforcement system. Notice of claim deadlines are not only standard features of many ERISA plans, but they also protect against the difficulties of proof, expenses and errors associated with stale claims.[9] A plan's written procedures and time limits for the filing of ERISA claims,[10] no less than the ERISA fiduciary review procedure required by § 503, are essential steps in the plan's administrative remedies.[11] A significant part of this Court's *Pilot Life* holding is that ERISA suits must be regarded as arising under federal law in a manner similar to those under § 301 of the Labor-Management Relations Act ("LMRA"). 481 U.S. at 55-56. Under § 301, an agreement's administrative remedies —including its written requirements and time limits for filing a claim—must be followed as a prerequisite to filing

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[9] *Central States, Southeast and Southwest Areas Pension Fund v. Mississippi Warehouse Corp.*, 853 F.Supp. 1053, 1058 (N.D. Ill. 1994); *Tiger v. AT&T Tech. Plan for Employees' Pensions, Disability Plan*, 633 F.Supp. 532, 534 (E.D. N.Y. 1986).

[10] 29 C.F.R. § 2560.503-1(b), (c).

[11] *See Kinkead v. Southwestern Bell Sick & Acci. Corp. Disability Benefit Plan*, 111 F.3d 67, 68 (8th Cir. 1997); *Kennedy v. System One Holdings, Inc.*, 835 F.Supp. 947, 950 n. 3 (S.D. Tex. 1993); *Christie v. K-Mart Corp. Employees Retirement Pension Plan*, 784 F.Supp. 796, 804 (D. Kan. 1992); *see also White v. Jacobs Engineering Group Long Term Disability Plan*, 896 F.2d 344, 346-47 (9th Cir. 1990) (plan's 60 day time limit for appealing denied claim is enforceable).

suit.[12] In permitting Ward's suit to proceed in admitted violation of the Plan's requirements, the decision below defers to the plaintiff but only at the cost of cutting across the grain of uniform federal law under ERISA, its antecedents in § 301 of the LMRA, and recent decisions by this Court. The carefully-crafted nature of ERISA's statutory scheme precludes the Ninth Circuit's continuing efforts to use state law doctrines to rewrite plan provisions and "fine-tune" the statute in favor of participants. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 147-148 (1985); *Pilot Life*, 481 U.S. at 54.

III. THE NINTH CIRCUIT'S PREEMPTION DECISION COMPLETELY DISRUPTS THE UNIFORMITY OF LAW INTENDED BY CONGRESS.

The Ninth Circuit's decision adopting the "*Elfstrom*" and "notice-prejudice" rules should be reviewed not only because it creates significant conflicts among the Circuits on ERISA preemption, but also because it has a far-ranging impact which destroys ERISA's key objectives of governing the administration of *both* self-funded and insured plans in accordance with an exclusive, uniform body of federal law. As this Court has noted, the "potential for conflict in substantive law" is "[*p*]*articularly disruptive*" under ERISA. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (emphasis added). The decision's severe repercussions—which will create a crazy quilt of conflicting plan rules across the land—warrant swift intervention by this Court.

The Ninth Circuit's new ERISA preemption standard, announced in connection with the "*Elfstrom*" rule, is so narrow and restricted, and the Court's disregard for conflicts-preemption is so complete, that the standard reopens

[12] *See, e.g., Laws v. Calmat*, 852 F.2d 430, 434 (9th Cir. 1988); *Brazinski v. Amoco Petroleum Additives Co.*, 6 F.3d 1176, 1179 (7th Cir. 1993); *Vaca v. Sipes*, 386 U.S. 171, 184-185 (1967).

a door closed by *Pilot Life* to state law suits based on virtually any claim arising out of a denial of plan benefits. Similarly, the Court's new standard for construing ERISA's "saving" clause is so broad and indiscriminate that it will arguably include virtually any common-law rule of general application that can be identified with the insurance industry regardless of whether it conflicts with ERISA's substantive provisions. Under the combined effect of these two standards, ERISA plan design, administration and civil enforcement will be challenged by an almost unlimited range of state laws. This will both conflict with *Pilot Life*, as discussed in more detail in section IV, below, and, at the same time, resurrect the same obstacles to plan growth and development—the "multiplicity of regulation" and " 'conflict . . . in law' "—that the Act was designed to eliminate. *Travelers*, 514 U.S. at 656-657 (citation omitted).

In misconsrtuing ERISA's preemption and "savings" clauses, the Ninth Circuit's decision produces a result exactly opposite to ERISA's fundamental purposes. To require all ERISA plans to be administered the same way in each state, Congress carefully crafted each of the Act's major components. It framed the definition of employee benefit plans explicitly to include *all* plans whether established "through the purchase of insurance or otherwise." ERISA § 3(1). It also inserted a "deliberately expansive" preemption provision designed to make the regulation of all ERISA plans " '*exclusively a federal concern.*' " *Pilot Life*, 481 U.S. at 45-46 (citation omitted) (emphasis added). Similarly, it added a "deemer" clause which precludes any plan from being "deemed" an "insurance company" or "engaged in the business of insurance." ERISA § 514(b)(2)(B). This significant qualification to the "saving" clause—which was completely overlooked by the Ninth Circuit—reflects Congress' commitment to free the administration of insured plans from the possibility of state regulation through some artful or overly-broad construction of the insurance exception. The "deemer" clause makes explicit Congress' objectives to

achieve federal uniformity in benefits law and plan administration by barring direct state regulation of plans irrespective of their funding mechanisms. When the "deemer" clause is thus read in conjunction with the Act's key objectives, it is clear that state regulation impacting plan administration and benefit payment—regulation which strikes at the very core of ERISA—would be preempted, notwithstanding that plan administration is conducted in part by an insurance company or a Blue Cross/Blue Shield organization.

A. Disruptions Caused By The "Notice-Prejudice" Rule.

The disruptions caused by the Ninth Circuit's error in allowing a state law rule, such as the "notice-prejudice" rule, to seize control over plan structure and administration, and the resulting conflict with ERISA's goals and *Pilot Life*, are discussed in detail at pages 18 through 22 of the petition for a writ of certiorari in the *Cisneros* case.

B. Disruptions Caused By The *"Elfstrom"* Rule.

In finding the California agency law announced in *"Elfstrom"* not preempted, the Ninth Circuit's decision not only once again flouts *Pilot Life*, but also conflicts with the law in other Circuits and produces a disruptive result that is contrary to ERISA's objectives. Apart from the Ninth Circuit, the courts have held that ERISA § 514(a) preempts state common-law agency doctrines which impact plan administration and the payment of benefits and thus "conflict with Congress' intent that a plan not be subject to a myriad of state laws." *See, e.g., Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-1490, 1493 (7th Cir. 1996) (ERISA preempts state law agency claims relating to a benefit denial). The decision below plainly conflicts with the Seventh Circuit's agency law decision in *Jass*. In addition, field preemption and conflicts-preemption bar the decision below because the common-law agency rule clashes

with ERISA's exclusive framework regulating fiduciary responsibility, claims-filing and civil enforcement.

In its haste to subject ERISA plans to state law control, the Ninth Circuit did not correctly analyze whether California agency law "relates to" an ERISA plan within the meaning of § 514(a) or is barred by field or conflicts-preemption. Instead, it mechanically applied state agency law based on a single, outdated, impliedly-overruled case, *Turrill v. Life Ins. Co. of North America*, 753 F.2d 1322 (5th Cir. 1985), which permitted state law to govern the administration of an insured ERISA plan. The Ninth Circuit failed to recognize the significance of the point that *Turrill* was decided *prior* to *Pilot Life* at a time when the courts consistently but incorrectly believed that ERISA preemption did not apply to suits alleging improper claims-handling or failure to pay benefits under insured plans. Accordingly, it was an anachronistic, direct contravention of *Pilot Life* for the Ninth Circuit to hold that ERISA does not preempt state law doctrines governing claims filing and benefit payment under an insured ERISA plan.

Four equally valid arguments establish that ERISA preempts state law agency rules such as the one embodied in *"Elfstrom,"* thus barring a multiplicity of federal-state regulation. First, the state law plainly "relates to" the Plan under the "ordinary meaning" of that term because it purports to regulate claims filing and processing and thereby dictates the payment of plan benefits. Indeed, Ward is attempting to use state law not only to assert the timely, oral "filing" of an ERISA claim with his employer, but also to bind the Plan's claims review fiduciary to such "filing" and obtain benefits precluded by the Plan's written terms. The state law thus has an obvious " 'connection with or reference to such a plan.' " *See Pilot Life*, 481 U.S. at 47-48; *District of Columbia v. The Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992).

"ERISA is designed to ensure the proper administration of pension and welfare plans." *Boggs v. Boggs*, 117

S.Ct. 1754, 1760 (1997). Acknowledging the need for uniformity of law, other Circuits have correctly held that ERISA § 514(a) preempts state agency law in a suit involving a denial of plan benefits. In *Jass, supra,* which involved a suit to hold a plan responsible for a medical provider's conduct in denying plan benefits, the Seventh Circuit held that the state agency law "related to" an ERISA plan and was therefore preempted by § 514(a). 88 F.3d at 1494. The court found that the agency argument was based on the plan's existence; the plan documents expressly stated that no agency relationship existed; the agency claim was a mechanism for seeking *benefits* not permitted by the plan documents; and applying state law would conflict with Supreme Court holdings that ERISA preempted " 'state laws that had the effect of regulating the structure or administration of ERISA plans or providing avenues outside of the ERISA framework to vindicate employees' rights under these plans' " (citation omitted). Both the holding and reasoning of the Seventh Circuit are in conflict with the decision below. *See also Perkins v. Time Ins. Co.*, 898 F.2d 470 (5th Cir. 1990) (under ERISA, personal liability of another party cannot be imputed to insurer under agency law theory).

Second, in cases where the direct relationship between the plan and the state law is not so immediately obvious as the one here, this Court has held that whether the law "relates to" the plan within the meaning of ERISA § 514(a) should be based on " 'the objectives of the ERISA statute . . . as well as . . . the nature of the effect of the state law on ERISA plans.' " *California Div. of Labor Standards Enforcement v. Dillingham Const.*, 117 S.Ct. 832, 838 (1997) (citation omitted). Under this analysis, ERISA preempts state law that would *frustrate* ERISA's goals by imposing different regulations from state to state, or by permitting claimants governed by one state law to obtain "benefits in excess of what plan administrators intended to provide, and in excess of what the plan provided to employees in other States." *Travelers,* 514 U.S.

at 656-657, 658. State laws cannot "preclude uniform administrative practice." *Id.* at 660. The state agency law adopted by the Ninth Circuit spawns *all* of these vices by subjecting plan administration and benefit payment to a multiplicity of regulation not only between federal law and state law, but also—for multistate employers—among the conflicting laws of the 50 states.

Third, the Ninth Circuit's decision disrupts the uniformity of regulation secured by ERISA's fiduciary responsibility provisions. ERISA's fiduciary and co-fiduciary liability rules impose *personal* liability and damages on a fiduciary for its *own* acts causing loss to a plan. ERISA § 409(a); *Russell,* 473 U.S. at 139. The court, however, permitted Ward to proceed on a state law agency theory that UNUM, as a "principal" and co-fiduciary, was personally liable for any ERISA violation by the employer in failing to ensure that he timely filed a written notice and proof of claim with UNUM. App. at 24a to 25a. As indicated, Ward was a CEO who admittedly had received a certificate of coverage which described the procedures and deadlines for submitting a claim to UNUM, and also participated in annual meetings where the Plan was reviewed. *Id.* at 29a, 32a to 33a. ERISA did not require the employer to do still more. ERISA's reporting and disclosure rules "may not be a foolproof informational scheme, although it is *quite thorough.* Either way, *it is the scheme that Congress devised.*" *Curtiss-Wright,* 514 U.S. at 84 (emphasis added). Even if the employer had violated ERISA by not seeking Ward out to give him further, specialized information about claims-filing, the Ninth Circuit still erred in permitting him to use state law agency doctrine to impute such a violation to UNUM as a co-fiduciary. App. at 25a. ERISA explicitly places the reporting and disclosure obligations *personally* on the Plan Administrator, §§ 105(b)(1), 502(c), and no other party can be held liable for such a violation, *see, e.g., McKinsey v. Sentry Ins. Co.*, 986 F.2d 401 (10th Cir. 1993). Further, ERISA's co-fiduciary liability rules im-

pose liability only where the co-fiduciary has *actual knowledge* of a breach by its co-fiduciary but fails to act.[18] Within the Plan's time limit for filing written notice and proof of claim, UNUM had no knowledge that Ward claimed to be "disabled" or had purportedly so advised his employer.

Fourth, the state law agency rule adopted by the Ninth Circuit runs afoul of conflicts-preemption and the exclusivity of ERISA's civil enforcement scheme for dual reasons. First, it conflicts with ERISA's fiduciary responsibility rules; second, it seeks to control benefit payment contrary to the Plan's written terms. In an attempt to suggest otherwise, the Ninth Circuit opined: "[N]or does *Elfstrom* create an 'alternative enforcement mechanism' for ERISA plan obligations beyond those set forth in the statute." App. at 21a to 22a. This conclusion is 180 degrees off course. The decision below provides the clearest possible example of an "alternate enforcement mechanism" triggering ERISA preemption. It would permit a state law rule to require the *payment* of plan benefits under circumstances where a claim denial is mandated by the Plan itself, ERISA's fiduciary responsibility rules and its exclusive civil enforcement scheme.

IV. THE NINTH CIRCUIT'S PREEMPTION DECISION IS AN ATTEMPT TO CIRCUMVENT THIS COURT'S CONTROLLING *PILOT LIFE* DECISION.

The holding and reasoning of this Court's unanimous decision in *Pilot Life* also preclude the Ninth Circuit's holdings that in a suit to recover plan benefits the "notice-prejudice" and "*Elfstrom*" rules escape ERISA preemption.

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[13] ERISA § 405(a)(1), (3); H.R.Rep. No. 1280, 93d Cong., 2d Sess. 304 (1994) (actual knowledge is required; there is no duty of investigation); *Davison v. Cook*, 564 F.Supp. 225, 237 (E.D. Va. 1983), *aff'd. mem.*, 734 F.2d 10 (4th Cir. 1984), *cert. denied* sub nom., *Accardi v. Davidson*, 469 U.S. 899 (1984); *Justice v. Bankers Trust Co., Inc.*, 607 F.Supp. 527, 536 (D.C. Ala. 1985).

Pilot Life held that ERISA preempts state law causes of action alleging an insurance company's "improper processing of a claim" and failure to pay plan benefits. It held that these causes of action plainly "related to" the plan and were not preserved by the "saving" clause. Additionally, it held that ERISA would bar these causes of action—even if the "saving" clause were applicable—because they conflict with one of ERISA's substantive provisions, its exclusive civil enforcement scheme in § 502(a). 481 U.S. at 51-57. In the present case, the Ninth Circuit concluded that Ward's failure to submit timely proof of his claim as required by the Plan does not necessarily invalidate his claim under § 502(a)(1)(B) in light of the "notice-prejudice" rule. It also permitted him to go forward under a state law agency rule which clashes with ERISA's intricate framework for claims-filing and processing, plan administration and fiduciary responsibility. The decision permits the identical result prohibited by *Pilot Life*: state common law rules purporting to govern the processing of claims allow a recovery that is both unavailable under the plan and in conflict with ERISA's substantive provisions, here its fiduciary responsibility and civil enforcement sections.

The Ninth Circuit's decision on the two state law rules contravenes not only the Court's holding in *Pilot Life* but also its reasoning. In *Pilot Life*, the Court first held that ERISA § 514(a) preempts state causes of action based on allegedly improper processing of claims and failure to pay benefits because such actions manifestly "relate to" an ERISA plan in the sense of having " 'a connection with or reference to such a plan.' " 481 U.S. at 47-48. In construing ERISA's "saving" clause, the Court evaluated Mississippi's "law of bad faith" under the common-sense and McCarran-Ferguson Act tests, then ruled that "we are obligated in interpreting the saving clause to consider . . . [its] role . . . in ERISA as a whole." Because the plaintiff's "bad faith" claims sought remedies for improper claims processing and failure to pay benefits, a sub-

ject already addressed in ERISA's enforcement scheme, the Court reasoned that "our understanding of the 'saving' clause must be informed by the legislative intent concerning the civil enforcement provisions provided by ERISA section 502(a)." *Pilot Life*, 481 U.S. at 52. The Ninth Circuit completely failed to consider the preemption and "saving" clauses in this broader context.

To determine legislative intent, this Court evaluated the structure, language and purposes of the statute. First, the Court observed that § 502 is one of three statutory sections aimed at enforcing ERISA; the other two are § 503, governing the processing of claims and the fiduciary review of denied claims, and § 501, which provides criminal penalties for certain violations. *Pilot Life*, 481 U.S. at 52-53. Second, the Court noted that the language of the statute does not provide for the extra-contractual damages and other remedies that the plaintiff was seeking against the insurance carrier. Rather,

> the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others . . . would be completely undermined if ERISA-plan participants . . . were free to obtain remedies . . . that Congress rejected in ERISA.

Pilot Life, 481 U.S. at 54. Third, the Court determined that Congress intended to model ERISA's civil enforcement provisions upon § 301 of the LMRA which "preempts any 'state-law claim whose resolution is substantially dependent upon the analysis of the terms of an agreement made between the parties in a labor contract.'" *Id.* at 55 (citation omitted). Thus, Congress intended "that *all* suits . . . asserting improper processing of [ERISA] claims . . . be treated as federal questions governed by § 502(a)." *Id.* at 56 (emphasis added).

Ward's claim based on the two state law rules fails under this analysis for a panoply of reasons. ERISA preempts a state law cause of action based on a fiduciary's failure to pay plan benefits. Under *Pilot Life*, such a claim obviously "relates to" an ERISA plan and is preempted by § 514(a). Similarly, not only field preemption but also conflicts-preemption bar Ward's state law claims pursuant to *Pilot Life*. ERISA §§ 502(a), 503 and 29 C.F.R. § 2560.503-1(c)-(g) contain detailed, exclusive provisions governing the filing and processing of ERISA claims, and the filing of suits for relief when administrative remedies are exhausted. Section 503 requires "*every* employee benefit plan" to comply with benefit claims regulations issued by the Secretary of Labor (emphasis added). Those regulations, in turn, specify that a plan's claims procedure may provide for the filing of claims with an insurance company, and that "a claim is filed when the requirements of a reasonable claim filing procedure . . . have been met." 29 C.F.R. § 2560.503-1(c)(d). Under ERISA's fiduciary review procedure for denied claims, the "fiduciaries" include an insurance company, or a Blue Cross/Blue Shield organization, serving as claims review fiduciary. *Id.* at § 2560.503-1(g)(2). By statute, these fiduciaries must follow the plan's written terms. ERISA § 404(a)(1)(D). Correspondingly, a participant who exhausts those administrative procedures may only file suit to recover benefits "*due* . . . under the *terms* of [the] plan." ERISA § 502(a)(1)(B) (emphasis added). This exclusive structure for fiduciary responsibility and civil enforcement would be "completely undermined if ERISA-plan participants" such as Ward could use state law doctrines to obtain benefits contrary to the plan's written terms and ERISA's civil enforcement scheme. *Pilot Life*, 481 U.S. at 54. Accordingly, the *Pilot Life* analysis precludes the decision below.

V. THE QUESTIONS PRESENTED BY THIS PETITION HOLD IMPORTANT IMPLICATIONS FOR ERISA PLANS THAT SHOULD BE ADDRESSED BY THIS COURT.

The Ninth Circuit's decision adopting the state law "notice-prejudice" and agency rules will impose a multiplicity of conflicting federal-state regulation on insured ERISA plans. Additionally, it will surrender significant portions of ERISA plan administration to the varying laws in the 50 states. All of this runs exactly contrary to ERISA's primary goals of ensuring a "uniform body of benefits law," *Travelers*, 514 U.S. at 645, making the administration of both self-funded and insured plans "'exclusively a federal concern,'" *Pilot Life*, 481 U.S. 45-46 (citation omitted), and "minimiz[ing] the need for interstate employers to administer their plans differently in each state in which they have employees," *Shaw*, 463 U.S. at 105.

Unless corrected, the Ninth Circuit's decision along with the Sixth Circuit's decision in *Davies*, 128 F.3d at 940—coupled with the Circuit conflicts over ERISA preemption—will create enormous confusion and difficulty in the design and administration of thousands of insured welfare plans across the country. Exactly the same hardships will affect pension plans with insurance funding. This confusion and uncertainty will spread into the courts as claim denials which are clearly proper under ERISA are made uncertain by the imprecise parameters of the Ninth Circuit's new view of the "saving" clause, and its narrow reading of the scope of ERISA preemption. Additionally, the adverse effects will not be limited to plan administration within the Sixth or Ninth Circuits. ERISA provides for nationwide service of process, and permits a suit to be filed in any district where the plan is administered, the breach of fiduciary duty took place, or a defendant resides or may be found. ERISA § 502(e)(2); *see, e.g., Varsic v. United States Dist. Ct.*, 607 F.2d 245, 248 (9th Cir. 1979). Consequently, the vast majority of insured plan sponsors coast to coast now risk not only that

the structure of their plans may be overturned, but also that the plan's administration and benefit payments may be subject to conflicting federal and state regulation pursuant to the Ninth Circuit's unprecedented decision and the parallel Sixth Circuit decision.

The practical consequences of the Ninth and Sixth Circuits' decisions are staggering. Just in terms of major medical care plans alone, there are an estimated 4.5 million employer-sponsored plans [14] covering over 161 million individuals.[15] Overwhelming percentages of these plans either are insured, with a large subset being Blue Cross/Blue Shield plans, or are self-funded plans with stop-loss insurance.[16] More than 9 out of 10 such plans delegate some portion of ERISA claims-handling and payment—and the fiduciary review authority mandated by ERISA § 503—to insurance companies, Blue Cross/Blue Shield organizations or third-party administrators.[17]

Across the nation, plan sponsors need to be able to design insured ERISA plans without fear that their written terms will be overturned in one state or another through some artful but erroneous application of ERISA's preemption and "saving" clauses. The loss of discretion over plan design will only provide a strong disincentive to establish such plans in the first place. *See, e.g., Heath v. Varity Corp.*, 71 F.3d 256, 258 (7th Cir. 1995). Additionally, the "notice-prejudice" rule has been rejected by many states and varies considerably across the land; [18]

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[14] ADMINISTRATION OF THE EMPLOYEE RETIREMENT INCOME SECURITY ACT, REPORT OF THE SECRETARY OF LABOR TO CONGRESS at i (1987).

[15] STATISTICAL ABSTRACT OF THE UNITED STATES, p. 120 (117 ed. 1997).

[16] MERCER/FOSTER HIGGINS NATIONAL SURVEY OF EMPLOYER-SPONSORED HEALTH PLANS, Report 1997, 17-18.

[17] *Id.* at 18.

[18] Many jurisdictions consider a timely claim as a condition precedent to recovery and thus do not follow such a rule. Other states presume prejudice to the insurer and require the claimant to estab-

similarly, state agency law doctrines vary from state to state.[19] All of this practical uncertainty coupled with the differences in state law will create strong financial incentives for employers either to cut back or eliminate insured benefits altogether, or to use self-funded plans notwithstanding the greater stability and solvency of insured plans.

The plan administrators and claims review fiduciaries for these plans, moreover, can be expected to process literally millions of ERISA claims for disability, pension and health benefits annually. Unless this Court resolves the Circuit conflicts, it will be impossible for these administrators and fiduciaries to rely on a " 'uniform body' " of federal benefits law, or to engage in the "nationally uniform" plan administration which was a "basic thrust" of ERISA. *Travelers*, 514 U.S. at 656-657. Further, they will be unable to administer their plans both in compliance with the plans' written terms and the Ninth Circuit's decision. They cannot know whether to deny a claim on the basis of a clear plan limit, or to accept the claim under state law regarding "notice-prejudice" or agency without regard to the terms of their plan and thus breach an ERISA fiduciary duty. They cannot even know which opposing sets of federal and state laws to apply to determine those questions.

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lish its absence; still other states—such as California—require the insurer to prove "actual prejudice." *See* 13A George J. Couch *et al.*, *Couch Cyclopedia of Insurance Law* § 49.49 at 276-77 (2d ed. 1982).

[19] *See, e.g., Metropolitan Life Ins. Co. v. Henry*, 217 Ind. 33, 24 N.E.2d 918 (1940) (under Indiana law, employer acting as middleman between insurer and employees is agent of employees); *First National Bank of Anson County v. Gatewood*, 303 N.C. 203, 214-15 278 S.E.2d 507 ("case law in this jurisdiction [North Carolina] . . . establishes that the employer-master policyholder is not ordinarily the agent of the insurer"); *Brezan v. Prudential Insurance Co. of America*, 507 F.Supp. 962, 966 (E.D.Pa. 1981) (under Pennsylvania law, group policyholder has no obligation to ensure that terms of group policy are correctly transmitted to employees); *Dawes Mining Co. v. Callahan*, 246 Ga. 531, 272 S.E.2d 267 (1980) (in Georgia, employer is agent of insurer, and insurer has imputed knowledge of information transmitted to employer).

The Ninth Circuit acknowledged in *Cisneros* the direct conflict between California's "notice-prejudice" rule and ERISA, stating that the rule made the plan "*more difficult to administer*" and caused "a plan's written terms [to be] *altered*." 134 F.3d at 947 (emphasis added). In the same manner, the "*Elfstrom*" rule requires the payment of benefits under circumstances where the Plan itself and ERISA's fiduciary responsibility and civil enforcement provisions require a claim denial. The decision thus presents, in two important respects, a "*direct clash* between state law and the provisions and objectives of ERISA," one where preemption necessarily arises because " 'compliance with both federal and state regulations is a *physical impossibility*.' " *Boggs v. Boggs*, 117 S.Ct. 1754, 1762 (1997) (citation omitted) (emphasis added). To allow state law rules not only to encroach on ERISA's exclusive framework for fiduciary standards and plan administration—but to "alter" the plan's written terms, and to permit a suit for benefits contrary to those terms—completely undermines a number of ERISA's most significant and highly-regulated areas. It also wreaks havoc on the important principle of uniformity of law upon which ERISA is based.

Intervention by the Court is critical to restore the carefully-crafted balance between state and federal law struck by Congress in ERISA and to reestablish the preeminence of ERISA's statutory scheme. ERISA plans are not only "affected with a national public interest," § 2(a), 29 U.S.C. § 1001(a), but the appropriate balance between competing federal and state law is of paramount concern to the nation's employee benefit plan system. Given the "centrality of pension and welfare plans in the national economy," *Boggs v. Boggs*, 117 S.Ct. at 1760, it is vital that this Court decide the two significant, far-reaching ERISA preemption issues presented by this case, and resolve the existing Circuit conflicts.

CONCLUSION

For the foregoing reasons, petitioner urges the Court to grant a writ of certiorari in this case.

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May 20, 1998

APPENDIX

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APPENDIX

UNITED STATES COURT OF APPEALS
NINTH CIRCUIT

No. 95-56269
D.C. No. CV-94-1454-MHH

Filed February 3, 1998

JOHN E. WARD,
Plaintiff-Appellant,
v.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN, and UNUM LIFE INSURANCE COMPANY OF AMERICA,
Defendants-Appellees.

Appeal from the United States District Court
for the Southern District of California

Argued and Submitted January 9, 1997—
Pasadena, California

Before Betty B. Fletcher and Stephen S. Trott,
Circuit Judges, and Bruce S. Jenkins,* District Judge

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* Honorable Bruce S. Jenkins, United States Senior District Judge for the District of Utah, sitting by designation.

OPINION

JENKINS, District Judge:

John E. Ward ("Ward"), former President and CEO of Management Analysis Company ("MAC"), brought this action under § 502 of the Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1132, seeking to recover benefits pursuant to his former employer's long-term disability plan. The United States District Court for the Southern District of California granted summary judgment in favor of the Management Analysis Company Employee Disability Benefit Plan (the "MAC Plan") and UNUM Life Insurance Company of America ("UNUM") on the ground that Ward's claim for benefits under UNUM's long-term disability policy was timely under the notice and proof of claim provisions of that policy. In light of our ruling in a related case, Cisneros v. UNUM Life Insurance Company of America, —— F.3d —— (9th Cir. 1998), that under California law, UNUM must show actual prejudice resulting from a claimant's untimely submission of proof of a claim before it may deny benefits under a plan governed by ERISA, we reverse the judgment in favor of UNUM and the MAC Plan and remand the case for further proceedings. We also remand for a determination of whether MAC received timely notice and proof of Ward's claim of disability while acting as a plan fiduciary and agent of UNUM, should that determination become decisive of the question of timeliness.

I

Effective November 1, 1983, UNUM issued a Group Long Term Disability Policy to MAC as an insured employee welfare benefit plan governed by ERISA. An employee certificate booklet summarizing the plan benefits was prepared and distributed in quantity to MAC employees, including Ward.

Ward served as President and Chief Executive Officer of MAC until, after being asked to resign by the Board of Directors on May 5, 1992, he resigned on May 8, 1992. In May of 1992, Ward was already suffering from diabetic neuropathy, and avers that prior to his resignation, he had begun experiencing severe and disabling leg pain resulting from that condition.

The nature and extent of his illness and resulting disability were diagnosed by December of 1992. In early 1993, Ward applied for and received state disability benefits, and contacted the MAC human resources division to discuss extension of his continuation insurance coverage under COBRA. In July 1993 he received a determination that he was eligible for Social Security disability benefits, a copy of which he forwarded to the MAC human resources division.

Ward states that he was actually unaware of the availability of the MAC Plan long-term disability benefits until April 1994, when he discovered a booklet describing the coverage among papers in his safety deposit box. Ward completed an application for long-term disability benefits and forwarded the same to MAC. MAC completed the employer information section of the application and forwarded the same to UNUM.

UNUM received notice and proof of Ward's claim on April 11, 1994. By letter dated April 13, 1994, UNUM informed Ward that his claim for benefits was denied as untimely under the terms of the policy. Through counsel, Ward requested that UNUM review the denial of his claim, and by letter dated July 12, 1994, UNUM informed Ward that it had reviewed his claim and affirmed its denial because it was "beyond the time frame stipulated in the policy."

Plaintiff filed his complaint against the MAC Plan to recover his claimed benefits under ERISA on September 15, 1994. UNUM appeared as a defendant and filed an

answer on behalf of itself and the MAC Plan on November 23, 1994. On August 8, 1995, the district court granted the defendants' motion for summary judgment, concluding that under the terms of UNUM's policy as written, "plaintiff's claim was late and therefore defendant was not obligated to honor plaintiff's claim for long-term disability benefits."

The district court entered judgment on August 17, 1995, and Ward filed a timely notice of appeal.

II

We review the district court's grant of summary judgment de novo. Bagdadi v. Nazar, 84 F.3d 1194, 1197 (9th Cir. 1996). Whether ERISA preempts state law is a question of law which we review de novo. Inland Empire Chapter of Associated General Contractors v. Dear, 77 F.3d 296, 299 (9th Cir. 1996). We also review de novo the principles of contract interpretation as applied to the facts, including the district court's interpretation of insurance policy language. O'Neill v. United States, 50 F.3d 677, 682 (9th Cir.), cert. denied, 116 S. Ct. 672 (1995).

III

While in his brief Ward lists several issues and makes a series of assertions concerning agency theory under Elfstrom v. New York Life Ins. Co., 67 Cal. 2d 503, 432 P.2d 731, 63 Cal. Rptr. 35 (1967), fiduciary duty under ERISA, and the potential liability of the MAC Plan, the appellees aptly restate the central issue now before us on appeal: "Did the District Court correctly hold that the plaintiff failed to timely submit written notice and proof of claim to UNUM as required by the express terms of the MAC Plan and applicable federal law under ERISA?"

UNUM expressly conditions payment of benefits upon submission of proof of claim within the time limits set forth in the policy. Section VI.F.2 of UNUM's policy

provides that proof "may not be given later than one year after the time proof is otherwise required," in this instance, "no later than 90 days after the end of the [90-day] elimination period." [1] Section VI.I provides that benefits will be paid "[w]hen the company receives proof of claim." Read together, these provisions logically and unambiguously establish that, under the policy, timely submission of proof is a condition precedent to payment of benefits.

Under the admitted facts of this case, Ward became permanently disabled on May 5, 1992. Using Ward's disability onset date of May 5, 1992, UNUM calculated that his proof of claim must have been received no later than November 5, 1993 in order to be deemed timely under the policy provision.[2] Ward did not submit notice or proof of his claim directly to UNUM until April 11, 1994. Ward's submission of notice and proof of his claim plainly was untimely under the express terms of the UNUM policy.

However, in light of our recent opinion in Cisneros v. UNUM Life Insurance Company of America, —— F.3d —— (9th Cir. 1998), untimeliness under the express terms of the policy does not end the inquiry, at least as to consequence. Cisneros holds that a claimant's failure to submit timely proof of claim does not necessarily result in the denial of benefits. Cisneros acknowledges that the California "notice-prejudice" rule remains in force respecting benefit plans governed by ERISA as a state law "which regulates insurance" under ERISA's savings clause, 29 U.S.C. § 1142(b)(2)(A). Under the "notice-prejudice" rule, the insurer of an ERISA benefit plan may not deny benefits by reason of untimely notice or submission of

---

[1] The MAC Plan documents provide that the "elimination period" consists of the 90-day period following the date of onset of the insured's disabilty.

[2] The district court's reference to a December 5, 1993 cutoff date appears to be simple mathematical error.

proof of claim unless the insurer proves that it has suffered actual prejudice because of the delay. Id. at 67375.[3]

Contrary to UNUM's assertion in its brief, we are not persuaded that passage of time alone establishes prejudice as a matter of law. See id. at 673, 675 (citing Shell Oil Co. v. Winterthur Swiss Ins. Co., 15 Cal. Rptr. 2d 815, 845 (Ct. App. 1993)). Whether UNUM suffered actual prejudice as a result of Ward's untimely notice remains a genuine issue of material fact. See Select Ins. Co. v. Superior Court, 276 Cal. Rptr. 598, 602 (1990). Thus, we reverse the district court's judgment in favor of UNUM.

Because neither the plan administrator nor the district court addressed the question of whether the notice-prejudice rule applied to Ward's claim, neither the plan administrator nor the district court determined whether UNUM suffered actual prejudice flowing from Ward's untimely notice and proof of claim.[4] Accordingly, we remand the case to the district court with instructions to remand to the plan administrator for a factual determination as to whether UNUM suffered actual prejudice by virtue of Ward's untimely submission of proof.

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[3] At the August 3, 1995 hearing on the motion for summary judgment, the district court inquired:

> THE COURT: Is there a body of law that then says that you have to—the company has to show some prejudice?
>
> MR. SMITH: No, not—not under ERISA. And we have cited as the Court knows, four cases, . . . all of which interpreted this plan language, and all of which, in circumstances almost identical to this, held that the proof of claim had not been timely provided—
>
> THE COURT: Now—MR. SMITH—really is under ERISA, and it is those cases that we would submit are controlling.

Among the four cases referred to by UNUM counsel was the district court disposition in the Cisneros case, now reversed on the precise issue raised by the court's question just quoted.

[4] While the district court noted in passing that "[t]he delay in filing precludes UNUM from definitively determining whether plaintiff's disability existed on the date alleged in his claim," the comment was made in the context of a broader policy discussion concerning time limits on claims rather than as a finding of fact based upon a specific evidentiary record. There appears to be little evidence in the present record bearing upon the question of actual prejudice. Paragraph 12 of the Declaration of John A. Houser, III, dated March 29, 1995, makes the conclusory assertion that "[d]uring that nearly two year period" between the onset of Ward's disability and the receipt by UNUM of notice, "UNUM was without knowledge that plaintiff claimed he was 'disabled' and was thereby deprived of the opportunity to fully evaluate his claim and to determine the extent of his disability at the time he claimed to be disabled," but offers no specific evidence showing how that evaluation has been impaired in this case. In fact, the Houser Declaration indicates that UNUM did not undertake to investigate, evaluate or determine Ward's claim on the merits, but assures that "[h]ad plaintiff timely filed his claim for disability benefits under the Policy, UNUM would have conducted a thorough claim investigation." Id. at P11 (emphasis added). On remand, UNUM has the burden to prove actual prejudice, that is, that Ward's delay would have prevented "a thorough claim investigation" in April of 1994 that otherwise would have been possible through November 5, 1993.

IV

Ward addresses the timeliness of his claim in another way: he asserts that actual notice of his disability given to MAC as early as March of 1993 operates as notice to UNUM as early as March of 1993 because under California law, an employer who participates in the administration of a group insurance policy acts as an agent of the insurer. He relies on Elfstrom v. New York Life Ins. Co., 67 Cal. 2d 503, 432 P.2d 731, 63 Cal. Rptr. 35 (1967), as authority for this proposition. Ward further asserts that if the Elfstrom rule is somehow preempted by ERISA, this court should adopt a like rule as a matter of federal common law. Moreover, Ward asserts that MAC breached its duties as an ERISA co-fiduciary to inform him of the availability of long-term disability benefits under the UNUM policy, to receive notice of his claim, and to assist him in furnishing appropriate proof of his claim to UNUM, breaches which Ward contends UNUM was

obliged to remedy. See 29 U.S.C. § 1105(a) ("a fiduciary with respect to a plan shall be liable for a breach of fiudciary responsibility of another fiduciary with respect to the same plan in the following circumstances: . . . (3) if he has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.").[5]

The Elfstrom Rule

In Elfstrom, the employer, Fullerton Publishing Co., had obtained a group life insurance policy for the benefit of its employees from the defendant, New York Life. The plaintiff was president and majority shareholder of Fullerton and the father of Brenda, the deceased employee, as well as the beneficiary under his daughter's life insurance certificate. Fullerton's bookkeeper, Mr. Still, administered the group policy under the direction of a New York Life group representative, following the directions set forth in a manual supplied by New York Life for that purpose. Mrs. Still mistakenly included Brenda as an insured in monthly reports to defendant insurer when, in fact, Brenda was not eligible, because her employment at the minimum salary required had terminated before expiration of the waiting period necessary for coverage. The premiums were paid until Brenda's death, seven months after expiration of the waiting period. Under these facts, the California Supreme Court held that the duties of the employer, discharged by Mrs. Still, in administering

[5] As Ward noted in his opening brief, whether an individual plan beneficiary may seek relief in his own behalf for breach of fiduciary duty under ERISA was raised in Varity Corp. v. Howe, 116 S. Ct. 1065 (1996). Varity answered that question in the affirmative, holding that plan participants and beneficiaries may sue for individual "appropriate equitable relief" pursuant to § 502(a)(3) of ERISA, 29 U.S.C. § 1132(a)(3), and are not limited solely to relief in favor of the plan itself as in Massachusetts Mut. Life Ins. Co. v. Russell, 473 U.S. 134, 144 (1985), construing ERISA § 502(a)(2). Id. at 1075-79.

the group life insurance policy, made it the agent of defendant insurer, and that the insurer was bound by the mistakes of the employer (per Mrs. Still) acting within the scope of the agency, provided the plaintiff (beneficiary) was acting in good faith in directing her to effect coverage for Brenda.

We are convinced that the employer is the agent of the insurer in performing the duties of administering group insurance policies. It cannot be said that the employer acts entirely for its own benefit or for the benefit of its employees in undertaking administrative functions. While a reduced premium may result if the employer relieves the insurer of these tasks . . . the insurer also enjoys significant advantages from the arrangement.

67 Cal. 2d at 512-13, 432 P.2d at 737. For the Elfstrom court, agency depended on the question of control:

The most persuasive rationale for adopting the view that the employer acts as the agent of the insurer . . . is that the employee has no knowledge or control over the employer's actions in handling the policy or its administration. An agency relationship is based upon consent by one person that another shall act in his behalf and be subject to his control. . . . It is clear from the evidence regarding procedural techniques here that the insurer-employer relationship meets this agency test with regard to the administration of the policy, whereas that between the employer and its employees fails to reflect true agency. The insurer directs the performance of the employer's administrative acts, and if these duties are not undertaken properly the insurer is in a position to exercise more constricted control over the employer's conduct.

67 Cal. 2d at 513-14, 432 P.2d at 738; see also Prudential Ins. Co. of America v. State Bd. of Equalization, 21 Cal. App. 4th 458, 482, 26 Cal. Rptr. 2d 287, 303 (1993) ("As expressed in Elfstrom, the agency relationship was shown by the insurer's control over the book-

keeper's performance of tasks relating to the insurance, i.e., the bookkeeper/agent performed functions under the insurer/principal's direction and for the principal's benefit.").

In reaching its conclusions regarding agency, Elfstrom cited this court's earlier decision in John Hancock Mut. Life Ins. Co. of Boston v. Dorman, 108 F.2d 220 (9th Cir. 1939). In John Hancock, Western Bakeries, the employer, "handled" the insurance under a group life/disability insurance master policy obtained for the benefit of employees; Western Bakeries had accepted insurance applications, determined employee eligibility, issued certificates of insurance, and collected premiums, all of which it then reported to the insurer. We held that the employer was the insurer's agent in handling these tasks and that acceptance of premiums by the insurer through its agent/employer estopped the insurer from claiming that the insured was not an employee within the meaning of the policy. 108 F.2d at 222-23, 224.

More recent California cases echo the Elfstrom/John Hancock rule. In McCormick v. Sentinel Life Ins. Co., 153 Cal. App. 3d 1030, 200 Cal. Rptr. 732 (1984), the California Court of Appeals explained:

In Elfstrom v. New York Life Ins. Co. (1967) 67 Cal.2d 503, 505, 63 Cal.Rptr. 35, 432 P.2d 731, our high court considered whether the acts of an employer who administered a group health insurance policy could be attributed to the defendant insurer. After reviewing conflicting cases from other jurisdictions, the court concluded the employer was acting as the insurer's agent and hence the insurer was liable for the employer's conduct. (Id., at p. 508, 63 Cal.Rptr. 35, 432 P.2d 731, citing Rest.2d Agency, §§ 165, 282(2), and pp. 512-513.) In rejecting the view the employer acted as the employee's agent, the court cited the employer's assumption of the insurer's administrative functions and the employee's lack of control over the employer's actions in handling the policy. (Id., at pp. 513-514, 63 Cal.Rptr. 35, 432 P.2d 731; accord Bareno v. Employers Life Ins. Co. (1972) 7 Cal. 3d 875, 883, 103 Cal.Rptr. 865, 500 P.2d 889; Pantzalas v. Superior Court (1969) 272 Cal.App.2d 499, 504, 77 Cal.Rptr. 354.)

Here, the credit union, like the employer in Elfstrom performed administrative duties in connection with processing claims under Sentinel's disability policy. It is undisputed the credit union assumed such responsibilities as maling the initial claim form to McCormick, notifying Sentinel of a possible claim from McCormick, and apprising McCormick his claim was incomplete. It also appears likely McCormick had no control over the credit union's actions. Under these circumstances a triable issue exists as to whether the credit union was acting as Sentinel's agent. If the fact finder determines an agency relationship, as defined in Elfstrom, did exist, the credit union's acts can be attributed to Sentinel.

153 Cal. App. 3d at 1040-41, 200 Cal. Rptr. at 737; see also Metropolitan Life Ins. Co. v. State Bd. of Equalization, 32 Cal. 3d 649, 658-59, 652 P.2d 426, 431, 186 Cal. Rptr. 578, 583 (1982) (Elfstrom is controlling on issue whether an employer acts as the insurer's agent in administering group insurance policies); Bass v. John Hancock Mutual Life Ins. Co., 10 Cal. 3d 792, 797, 518 P.2d 1147, 1150, 112 Cal. Rptr. 95, 198 (1974) ("[W]e have held that the employer is the agent of the insurer in performing the duties of administering group insurance policies . . . and that accordingly the insurer shares responsibility for the employer's mistakes."); Caldwell v. United Bus Corp., 77 Cal. App. 3d 381, 383-84, 112 Cal. Rptr. 7, 8 (1986) ("The general rule in California is that the employer is merely the agent of the insurer in performing the duties of administering group health insurance policies.").

Other jurisdictions as well have adopted a similar approach to the agency question. See, e.g., Middleton v. The Russell Group, Ltd., 483 S.E.2d 727, 734 (N.C. 1997) (holding that "[a]n employer who performs administrative functions [under a group insurance policy], as in the instant case, is deemed to be the agent of the insurer," (citing Elfstrom)), and cases cited therein; Abiatti v. Buttura & Sons, Inc., 161 Vt. 314, 324, 639 A.2d 988, 993-94 (1994) (agency relationship may be founded upon the policyholder's performance of administrative tasks on behalf of the insurer); Kirkpatrick v. Boston Mut. Life Ins. Co., 393 Mass. 640, 645-46, 473 N.E.2d 173, 176-77 (1985) ("Whether or not the employer acts as the insurer's agent is a factual question to be resolved on a case by case basis."); Norby v. Bankers Life Co. of Des Moines, Iowa, 304 Minn. 464, 471-72, 231 N.W.2d 665, 670 (1975) ("the employer policyholder may, in appropriate circumstances, be found to be the agent of the group insurer of employees").

In Paulson v. Western Life Ins. Co., 636 P.2d 935 (Or. 1981), the Oregon Supreme Court held that whether an employer acted as agent for an insurer in administering a group policy presented a triable issue of fact. The Paulson court read Elfstrom and other cases as applying a rule expressed in these terms: "In the performance of a function delegated by the insurer to the employer, the employer is deemed to be the agent of the insurer." 636 P.2d at 941.[6]

[6] Paulson rejected the view that the cases divide into a "majority rule" and a "minority rule" concerning the employer-agency question:

> Our analysis of the decisions convinces us that many courts, even though they purport to apply a "majority rule" or a "minority rule," actually base their decision upon the facts relating to the division of functions between the insurer and the employer policyholder, and that any "majority" or "minority" rule is more apparent than real. It is more correct to say that when the plan is exclusively administered by the insurer, as a matter of law no agency relation exists between the insurer and the employer. But if the employer performs all of the administration of the policy, an agency relationship exists between the insurer and the employer, as a matter of law. Between these two extremes, as the division of functions becomes less separate, or to put it another way, as the employer assumes responsibility for more administrative or sales functions which are customarily performed by an insurer, a question of fact will arise as to the agency relationship between the insurer and the employer.

636 P.2d at 939.

The Paulson formulation of the Elfstrom rule appears sound. It also comports with our prior determination of the same issue in John Hancock.

MAC's Administration of the UNUM Policy

Central to Ward's agency theory under Elfstrom must be proof that MAC participated in the administration of UNUM's group disability insurance policy and performed insurance-related tasks delegated by or carried on under the direction and ultimate control of UNUM. Ward points to the fact that MAC was designated as plan administrator by the MAC Plan as well as to specific provisions of the UNUM policy (Sec. VI, P D) requiring MAC to furnish information to UNUM concerning employees who become eligible for coverage, whose coverage changes in amount, or whose coverage terminates.

Arguing that courts must follow an "absolute and literal interpretation" [7] of the language of ERISA plan docu-

[7] For this proposition, UNUM cites Madden v. ITT Long Term Disability Plan, 914 F.2d 1279, 1285-86 (9th Cir. 1990), cert. denied, 498 U.S. 1087 (1991). Headnote no. 7 of the Madden opinion recites that "[f]iduciary's delegate properly gave absolute and literal interpretation to long-term disability plan's definition of 'total disability', which required that employee was unable to engage in any occupation," but this synopsis does not accurately reflect the relevant portion of the Madden opinion. What we said was "Metropolitan's use of the Plan definition was clearly proper, because as an ERISA fiduciary, Metropolitan was required to apply the terms

ments, UNUM points to Section VI, Paragraph L of its long-term disability policy, which reads:

L. AGENCY

For all purposes of this policy, the policyholder acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company without a written authorization.

Averring that no such written authorization was ever issued to MAC, and "MAC's involvement in the LTD [long-term disability] claims process was, at most, acting as a conduit between MAC employees and UNUM," UNUM urges the conclusion that "MAC is not UNUM's agent."

Of course, the existence of an agency relationship generally presents a question of fact:

> Whether as between the parties their relationship is one of agency depends on their relations as they in fact exist under the agreement or acts of the parties, and the question is not governed by the stipulations of the parties.

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of the Plan. See ERISA, 29 U.S.C. § 1104(a)(1)(D) (1988)." 914 F.2d at 1286 n.6.

While this court has more recently admonished that "[a]n ERISA plan administrator abuses its discretion if it construes provisions of plan in a way that 'conflicts with plain language of plan,'" Saffle v. Sierra Pacific Power Co. Bargaining Unit Long Term Disability Income Plan, 85 F.3d 455, 458 (9th Cir. 1996) (quoting Taft v. Equitable Life Assur. Soc'y, 9 F.3d 1469, 1472 (9th Cir. 1993)), we have yet to endorse a rule of strict, absolute or literal construction of ERISA plan documents. Indeed, Saffle appears to reject a "literal" construction of plan language in favor of a "reasonable" one, consistent with case law from other circuits. See id. at 458-59 (citing Helms v. Monsanto Co., Inc., 728 F.2d 1416, 1420 (11th Cir. 1984) (rejecting arbitrator's "absolute and literal" interpretation of "totally and permanently disabled" to mean complete helplessness as unreasonable because it would render the entire plan meaningless and would contradict policies underlying ERISA); Torix v. Ball Corp., 862 F.2d 1428 (10th Cir. 1988) (same)).

> Thus, whether a particular relationship is that of agency does not depend on what the parties call it, and the parties cannot, where the relationship is in fact one of agency, change its nature by declaring that it is not an agency, nor can they, by calling their relations one of agency, make it so when it is not so in fact. The surrounding facts and circumstances determine the relationship, regardless of the understanding of the parties as to the exact nature of the relationship. . . .
>
> 2A C.J.S. Agency § 7 (1972) (footnotes omitted); accord, Wallace v. Sinclair, 114 Cal. App. 2d 220, 250 P.2d 154, 16061 (1953); American Marine Paint Co. v. Nyno Line, 70 Cal. App. 415, 233 P. 366, 369 (1924) ("nor does it matter whether or not his employment be called an agency"); 3 Am. Jur. 2d Agency § 21 (1986) ("The manner in which the parties designate the relationship is not controlling, and if an act done by one person in behalf of another is in its essential nature one of agency, the one is the agent of such other notwithstanding he is not so called." (footnote omitted)); 2 (pt. 2) Cal. Jur. 3d Agency § 12, at 170-73 & nn. 77-93 (1997) (citing Elfstrom). Ordinarily, an agency relationship may be established through evidence of control and apparent or applied authority, even where the parties have agreed to the contrary. See, e.g., Kuchta v. Allied Builders Corp., 21 Cal. App. 3d 541, 547, 98 Cal. Rptr. 588, 591 (1971) (notwithstanding that "the agreement itself stated that no such agency relationship was created, the declarations of the parties in the agreement respecting the nature of the relationship are not controlling."); Fernander v. Thigpen, 278 S.C. 140, 293 S.E.2d 424, 426 (1982).

However, UNUM also asserts that ERISA preempts the Elfstrom rule because Elfstrom imposes respondeat superior liability; according to UNUM, "ERISA's rule of personal fiduciary liability not only supersedes, but is inconsistent with, the doctrines of respondeat superior and

vicarious liability." Nor could the Elfstrom rule be adopted as a matter of federal common law because adoption of respondeat superior and vicarious theories would impermissibly "revise the text" of ERISA by adding causes of action or remedies not affirmatively authorized by the statute. See Mertens v. Hewitt Assoc., 508 U.S. 248, 259 (1993) ("The authority of courts to develop a 'federal common law' under ERISA . . . is not the authority to revise the text of the statute.").

No prior Ninth Circuit opinion has addressed the relationship of ERISA to state agency law,[8] or more specifically, whether ERISA preempts the rule of California state law announced in Elfstrom. Nor has any prior opinion of this court discussed whether under circumstances such as these, federal statutory or common law creates the agency relationship that Ward suggests.

Looking to case law from other circuits, Turrill v. Life Ins. Co. of North America, 753 F.2d 1322 (5th Cir. 1985), informs our inquiry. Turrill, an American Airlines facility maintenance mechanic, became disabled after a fall on a wet floor at the Dallas/Ft. Worth airport. The insurer had issued a group disability insurance policy to American Airlines that was in effect at the time of the accident. Turrill did not submit notice or proof of his claim directly to the insurer until more than two years after the accident. However, soon after the accident, he did submit an array of documentation concerning his injury to his employer. Reversing summary judgment in favor of the insurer on grounds of timeliness, the Fifth Circuit concluded that "a genuine issue of material fact

[8] We have noted, however, that Nationwide Mut. Ins. Co. v. Darden, 503 U.S. 318 (1992), "construed the term 'employee' in the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C.S 1002(6), as incorporating 'judicial agency law criteria for identifying master-servant relationships.' Id. at 319 . . . ." Coupar v. United States Department of Labor, 105 F.3d 1263, 1266-67 (9th Cir. 1997).

exists regarding the authority of American Airlines to receive proofs of loss" as an agent of the insurer. Id. at 1324. "Whether such an agency relationship existed bears heavily on the timeliness of Turrill's proof of loss. . . ." Id.

To resolve the agency question, the Turrill court looked both to Texas agency law and to ERISA.

Under the Employee Retirement Income Security Act of 1974 (ERISA), . . ., an employer who, like American Airlines, provides disability benefits through a group insurance policy owes fiduciary duties to the participating employees and their beneficiaries. See 29 U.S.C. § 1104 (a)(1) (1982) ("[A] fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and the beneficiaries.") The fiduciary obligations of such an employer easily include responsibility to take care that the insurance company receives documentation necessary under the group policy to achieve recovery on a just benefits claim. This is especially so if the documentation is already in the agent's hands.

ERISA thus obliged American Airlines to exercise care and diligence in assuring compliance with the proof of loss requirements of the master policy. It also required the employer to provide to participating employees extensive information regarding the plan. 29 U.S.C. § 1021 (1982).

ERISA compels the employer (or other plan fiduciary) to act affirmatively in administering and providing information on its employee benefits plan. In cases involving group policies, the requisite employer's efforts include determining employees' eligibility for coverage, enrolling them in the plan and group policy, advising them as to scope of benefits, collecting and forwarding premiums, and helping employees file claims. An insurance company normally performs these functions. But in group insurance

situations where ERISA applies, the employer and group insurer typically develop a course of dealing in which the employer substitutes for the insurer in a relationship that ERISA impliedly may require.

Under these circumstances, courts may properly infer an agency relationship. The group insurer's failure to disavow the sufficiency of the employer's performance of functions that ERISA requires the employer to perform can properly lead to a conclusion that the group insurer is representing that an agency relationship exists as to those functions. . . .

Id. at 1325 (footnote & citation omitted). The Turrill court held that "proof of an employer's ERISA-based reporting and fiduciary responsibilities with respect to a group insurance policy in itself raises an issue under Texas law as to the existence of an agency relationship between the employer and the group insurer." Id. Nothing in Turrill even hints that state agency law is somehow preempted by ERISA.

MAC's Fiduciary Duties Under ERISA

In enacting ERISA, Congress did not explicitly enumerate all the duties of an ERISA fiduciary, and did not describe every instance in which an employer acts in a fiduciary capacity, but intentionally left many of these details for the courts to develop in light of the special nature and purpose of employee benefit plans. Varity Corp. v. Howe, 116 S. Ct. 1065, 1070 (1996). ERISA contemplates that an employer often will act as both employer and plan fiduciary, but not all of the employer's business activities implicate ERISA's fiduciary duties. Id. at 1071.

At minimum, ERISA makes an employer who exercises "discretionary authority or discretionary responsibility" in plan administration a fiduciary:

> [A] person is a fiduciary with respect to a plan to the extent (i) he exercises any discretionary authority or discretionary control respecting management of such plan or exercises any authority or control respecting management or disposition of its assets . . . or (iii) he has any discretionary authority or discretionary responsibility in the administration of such plan.

29 U.S.C. § 1002(21)(A). An employer who performs "purely ministerial functions" in administering a plan may not be a fiduciary, but even so, "[t]he issue is not just how the duties are characterized, but what they are." IT Corp. v. General American Life Ins. Co., 107 F.3d 1415, 1419 (9th Cir. 1997); see also 29 C.F.R. § 2509.75-8, at D-2 (1996) ("[P]ersons who have no power to make any decisions as to plan policy, interpretations, practices or procedures" are not fiduciaries under ERISA).

In this case, MAC's activities as plan administrator included determining employees' eligibility for coverage, enrolling them in the plan, issuing certificates of insurance under the group policy, advising employees as to scope of benefits, collecting and forwarding premiums to UNUM, and on occasion, at least, helping employees file claims. In addition, the certificate of coverage and summary plan description pamphlet prepared by UNUM and distributed to MAC employees by MAC advises employees that MAC is the Plan Administrator, that "[t]he people who operate your Plan, called 'fiduciaries' of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries," and instructs employees that "[i]f you have any questions about your Plan, you should contact the Plan Administrator." [9]

Arguably, MAC has assumed fiduciary duties under ERISA in the administration of the MAC Plan.[10] Consis-

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[9] UNUM's certificate of coverage also counsels employees that "[i]f you have any questions about any terms and provisions, please contact the Insurance Administrator at your work location or write to our claims paying office."

tent with Turrill, proof of MAC's fiduciary duties under ERISA with respect to UNUM's group insurance policy raises an issue under California law as to the existence of an agency relationship between the employer and the group insurer in light of Elfstrom.

ERISA Preemption

Within its reach, ERISA regulates plans which provide employees with pension and welfare benefits. "It is a comprehensive statute designed to promote the interests of employees and their beneficiaries in employee benefit plans." Burgio and Campofelice, Inc. v. New York State Dep't of Labor, 107 F.3d 1000, 1007 (2d Cir. 1997). Section 514(a) of ERISA promotes uniform federal regulation of employee benefit plans by preempting "any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA, subject to limited exceptions. 29 U.S.C. § 1144(a). Section 514(a)'s purpose "was to minimize the administrative and financial burden of complying with conflicting directives among States and between States and the Federal Government. Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries." Ingersoll-Rand Co. v. McClendon, 498 U.S. 133, 142 (1990).

While § 514(a)'s language is "deliberately expansive," Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 46 (1987), ERISA does not preempt "if the state law has only a 'tenuous, remote, or peripheral' connection with covered plans, . . . as is the case with many laws of general applicability. . . ." District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125, 130 n.1 (1992) (quoting Shaw v. Delta Air Lines, Inc., 463 U.S. 85, 100 n.21 (1983)). In fields of traditional state regulation, ERISA preempts

[10] The term "fiduciary" has a broader meaning under ERISA than at common law because ERISA "defines 'fiduciary' not in terms of formal trusteeship, but in functional terms of control and authority over the plan." Mertens, 508 U.S. at 262.

state law if that is " 'the clear and manifest purpose of Congress.' " New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995) (quoting Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947)). The Supreme Court recently acknowledged the existenc eof "myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." California Div. of Labor Standards Enforcement v. Dillingham Constr., 117 S. Ct. 832, 842 (1997).

In each instance, the intent of Congress controls our analysis of preemption under ERISA. Yet the statute itself offers little guidance as to when a state law "relates to" an ERISA plan within the meaning of § 514(a). In the Travelers case, the Supreme Court observed that courts "must simply go beyond the unhelpful text and the frustrating difficulty of defining its key term, and look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." 514 U.S. at 656. In light of legislative history indicating that "the basic thrust of the preemption cause . . . was to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans," the Travelers Court concluded that two types of state laws "relate to" employee benefit plans within § 514(a): laws that "mandat[e] employee benefit structures or their administration," and laws that "provid[e] alternative enforcement mechanisms." Id. at 657-58.

ERISA and Elfstrom

ERISA and Elfstrom are not anathema. Elfstrom does not dictate the benefits to be provided or the manner in which the plan will be administered. Elfstrom does not require an employer to participate in the administration of a group insurance policy or an insurer to delegate its functions to an employer.[11] Nor does Elfstrom create an

[11] In this case "California is not telling employers how to write their ERISA plans. Nor is it conditioning some requirement on

"alternate enforcement mechanism" for ERISA plan obligations beyond those set forth in the statute. Contrast Pilot Life, 481 U.S. at 55-57. Elfstrom simply describes in legal terms a relationship that already exists in fact.

As Turrill illustrates, the principle that an employer who undertakes responsibilities in administering an employee benefit plan assumes fiduciary duties under ERISA meshes smoothly with the Elfstrom rule that an employer who assumes such responsibilities in administering a group insurance policy acts as the agent of the insurer. Turrill, 753 F.2d at 1324-25; see also Middleton, 483 S.E.2d at 732-35 (on claim for unpaid benefits under ERISA § 502, Elfstrom rule applies to hold insurer accountable for employer's mistake in denying former employee COBRA continuation coverage; other state law claims preempted by ERISA).

Ostensibly, the legislative effort was to ensure that employee benefits are provided through an ERISA plan overseen by plan fiduciaries, including the plan insurer and those who the insurer may enlist to participate in the administration of the plan. Nothing in § 514(a) empowers a plan fiduciary to extend ERISA's preemptive reach by using policy language that negates agency law principles in favor of exonerating itself from the errors of those who act on its behalf. Cf. IT Corp., 107 F.3d at 1418 (any interpretation of a plan which prevents a plan fiduciary from being held liable as a fiduciary is void); 29 U.S.C. § 1110(a). Plan documents defining or disavowing a relationship do not have the status of the ERISA statute, particularly when the actions of the signators belie the document recitals.[12]

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how individual employers write their ERISA plans." WSB Elec., Inc. v. Curry, 88 F.3d 788, 796 (9th Cir. 1996); see Employee Staffing Services, Inc. v. Aubry, 20 F.3d 1038, 1041 (9th Cir. 1994).

[12] Merely reciting that "if the terms of your certificate of coverage and the policy differ, the policy will govern" does not resolve the question. Where the certificate remains silent on the subject of agency, the existence in fact of an agency relationship does not constitute a "term" of the certificate.

Whether an agent or not, if an employer/plan administrator exercises sufficient authority over the plan to become an ERISA fiduciary, contractual policy disclaimers could not limit fiduciary and co-fiduciary liability under ERISA. See IT Corp., 107 F.3d at 1418-19.

Even if UNUM could by agreement with MAC exonerate itself of its agency relationship as against MAC, there is no reason to suppose that the agreement would exonerate UNUM from its duties to participants and beneficiaries of the ERISA plan, or the conduct of those who act on its behalf with apparent authority. The employee participants did not sign the agreement bearing the agency disclaimer and they are entitled to have the plan administered in the interest of participants and beneficiaries. See 29 U.S.C. § 1104. Absent the insurer's over disavowal of the sufficiency of the employer's performance of functions under the plan, actually communicated, the participants and beneficiaries should be able to rely upon the relationships that exist. Nothing in ERISA suggests that in availing themselves of plan benefits, employee participants must sift plan documents for hidden disclaimers that the designated plan administrator does not act as agent for the plan or its insurer.[13] The statute must do more than set traps for the unwary.

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[13] UNUM cites Kennedy v. System One Holdings, Inc., 835 F. Supp. 947 (S.D. Tex. 1993), as rejecting a participant's claim that UNUM was estopped from denying his late claim based upon misrepresentations by the employer/plan administrator because, inter alia, "the Plan clearly and unambiguously provides that System One is not UNUM's agent . . . ." Id. at 951 (footnote omitted). Kennedy relies on policy language essentially identical to Section VI, Paragraph L of the long-term disability policy issued to MAC. See id. at 951 n.5. However, Kennedy does not discuss Turrill, and nothing in Kennedy suggests that the plaintiff gave his employer timely notice of his disability claim, or even that the employer had undertaken administrative responsibilities under the insurance policy in question. In fact, Kennedy identifies UNUM—not the em-

Applied in the context of this case, Elfstrom does not operate to create a cause of action against UNUM outside of the exclusive claim for unpaid benefits pursuant to § 502(a) of ERISA, 29 U.S.C. § 1132(a), pleaded in Ward's complaint. Contrast Kanne v. Connecticut Gen. Life Ins. Co., 867 F.2d 489, 494-95 (9th Cir. 1988) (state statutory claim for delayed benefits payment preempted by ERISA); Perkins v. Time Ins. Co., 898 F.2d 470, 474 (5th Cir. 1990) (state law tortious breach of contract and bad faith claims against insurer for nonpayment of benefits preempted by ERISA). Nor does Elfstrom alter the facts as between MAC and UNUM, or create an agency relationship that may or may not exist as a consequence of the parties' own course of dealing. The question ultimately for the district court under Elfstrom becomes whether MAC acted for UNUM and under UNUM's control in receiving and forwarding long-term disability claims, and thus whether timely notice to MAC of Ward's disability operated as timely notice to UNUM as well.

In the context of a claim for unpaid benefits under § 502(a), ERISA does not operate to preempt the application of the state law embodied in Elfstrom and its progeny to determine the question of timeliness of notice and proof of claim. We are not persuaded that Congress had as its clear and manifest purpose the abrogation of state agency law as it applies to insurers and employers administering group insurance policies.

Whether MAC acted as fiduciary and as agent of UNUM in administering the MAC Plan's long-term disability policy, particularly in receiving and forwarding

ployer—"as administrator of the long term disability benefits plan at issue in this case." Id. at 949; see also id. at 948 (plaintiff sought benefits under "an employee welfare benefit plan ('Plan') administered by UNUM"). Thus, Kennedy does not address the Elfstrom rule because the issue was not raised in that case.

Indeed, we could identify no reported case giving the effect to this language now urged by UNUM.

claims for benefits,[14] cannot be decided as a matter of law on the existing record. The questions of employer-insurer agency and employer fiduciary duty instead raise genuine issues of fact.[15]

However, these issues become material in this case only if the question of timeliness of submission of proof of claim to UNUM, including actual prejudice under Cisneros, is ultimately resolved adversely to Ward.

The judgment of the district court is REVERSED and the case is REMANDED to the district court with instructions to remand to the plan administrator for a determination as to whether UNUM suffered actual prejudice by reason of the delay in submission of Ward's notice of claim, and if necessary following remand to the plan administrator, to determine whether MAC acted as ERISA fiduciary and as agent of UNUM in administering the MAC Plan's long-term disability policy, particularly in receiving and forwarding claims for benefits, and if so, whether Ward furnished timely notice and proof of his disability to MAC, and if so, to what remedies Ward may be entitled.

[14] See Norby, 304 Minn. at 472, 231 N.W.2d at 670 ("The focus . . . should be on which specific and relevant administrative functions are performed by the employer on behalf of the insurer, with respect to the particular ground asserted for . . . nonpayment under the policy. . . . An employer may be considered an agent of an insurer for some purposes but not for others.")

[15] The extent of UNUM's liability, if any, for breach by a cofiduciary pursuant to 29 U.S.C. § 1105(a) depends, inter alia, on UNUM's knowledge of the breach, which raises even more issues of fact. That MAC has not been joined as a party to this litigation does not impair Ward's entitlement to relief under ERISA § 502(a)(1), but may raise procedural questions as to any further relief sought under § 502(a)(3). Cf. Madden, 914 F.2d at 1287 (" 'ERISA permits suits to recover benefits only against the Plan as an entity, . . . and suits for breach of fiduciary duty only against the fiduciary.' " (quoting Gelardi v. Pertec Computer Corp., 761 F.2d 1323, 1324-25 (9th Cir. 1985) (citations omitted)).

Moreover, to the extent that Ward may be entitled to receive payment of benefits pursuant to ERISA § 502(a)(1), further equitable relief under § 502(a)(3) may not be "appropriate." Varity Corp., 116 S. Ct. at 1079.

[Filed Mar. 23, 1998]

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 95-56269
D.C. No. CV-94-01454-MHH

JOHN E. WARD,
Plaintiff-Appellant,
v.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN (proper party name) UNUM Life Insurance Company of America,
Defendant-Appellee.

Before: FLETCHER and TROTT, Circuit Judges, and JENKINS,* District Judge

ORDER

The panel has voted to deny the petition for rehearing. Judges Fletcher and Trott vote to reject the suggestion for rehearing en banc and Judge Jenkins so recommends.

The full court has been advised of the suggestion for an en banc rehearing, and no judge of the court has requested a vote on the suggestion for rehearing en banc. Fed. R. App. P. 35.

The petition for rehearing is denied and the suggestion for rehearing en banc is rejected.

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* Honorable Bruce S. Jenkins, United States District Judge for the District of Utah, sitting by designation.

[Filed Aug. 8, 1995]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

Case No. CV 94-1454 H(AJB)

JOHN E. WARD,
Plaintiff,
vs.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,
Defendant.

ORDER GRANTING DEFENDANT'S MOTION FOR SUMMARY JUDGMENT

Defendant UNUM has filed a motion for summary judgment. Plaintiff opposes the motion. On August 3, 1995, the court held a telephone oral argument in this matter and both parties assented to having the matter heard on this date. Brooks Iler appeared on behalf of plaintiff John Ward and Jeffrey Smith appeared on behalf of defendant UNUM.

Having reviewed the papers submitted in this matter and having heard oral argument in the case, the court grants defendant's motion for summary judgment.

BACKGROUND

Plaintiff was the former Chief Executive Officer of Management Analysis Company ("MAC"). On May 8, 1992, plaintiff resigned from his position upon the request of the company's Board of Directors over financial concerns about a particular company project.

Throughout his nine years of employment with MAC, plaintiff had premiums for long-term disability insurance deducted from his paycheck. The disability policy is an insured employee welfare benefit plan called the Management Analysis Company Plan (the "Plan") and is issued by UNUM Life Insurance Company of America ("UNUM").

The issue in this case is whether plaintiff made a timely claim for benefits under the Plan. According to plaintiff's application for benefits, he first became aware of his disability on May 5, 1992. In December 1992, plaintiff received a diagnosis of diabetic neuropathy.

Following confirmation of his diagnosis, plaintiff filed a claim for state disability benefits. In or around late February or early March 1993, plaintiff received notice that his state benefits application had been approved. Plaintiff then contacted the Human Resources division of MAC to arrange for the continuation of his insurance coverage under COBRA. The company's Administrative Vice-President, Dexana MacQuarrie, forwarded materials regarding COBRA benefits to plaintiff and explained that plaintiff needed to get a disability determination from the Social Security Administration in order to extend his insurance benefits.

In July 1993, plaintiff received his Social Security award of disability, a copy of which he forwarded to MAC's Human Resources department. At that time, neither Maria Bonney, the employee handling plaintiff's health insurance coverage, nor Dexana MacQuarrie mentioned to plaintiff that he might obtain coverage under the Plan.

In April 1994, while cleaning out a safety deposit box, plaintiff discovered a booklet entitled "Your Long Term Disability Income Benefits." Upon discovering the pamphlet, plaintiff contacted Maria Bonney to determine whether he was covered under the long-term plan. Bonney told plaintiff that he was indeed covered and sent

him an application for long term disability benefits. Under the terms of the Plan, if plaintiff's claim had been approved, he would have been entitled to $13,000 per month for a period of forty-two months which adds up to a total available benefit of approximately $546,000.

Plaintiff completed the application and submitted it to MAC. MAC completed the employer section and forwarded the application to UNUM on April 11, 1994.

On April 13, 1994, UNUM advised plaintiff that his claim would not be reviewed because it was not submitted in a timely fashion. On June 6, 1994, plaintiff's counsel requested a review of UNUM's claim denial. Six days later, UNUM confirmed its denial of coverage. Plaintiff then filed this suit in federal court.

On May 8, 1995, the court denied without prejudice defendant's motion for summary judgment noting that there were unresolved material issues of fact in regards to the agency issue.

DISCUSSION

A. *Standard*

A motion for summary judgment shall be granted where "there is no genuine issue as to any material fact and . . . the moving party is entitled to judgment as a matter of law." FED R. CIV P. 56(c); *British Airways Bd. v. Boeing Co.*, 585 F.2d 946, 951 (9th Cir. 1978). Any doubt as to the existence of any issue of material fact requires denial of the motion. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 255 (1986). The opposing party cannot rest on the mere allegations or denials of his pleading, but must "go beyond the pleadings and by her own affidavits, or by the 'depositions, answers to interrogatories, and admissions on file' designate 'specific facts showing that there is a genuine issue for trial.'" *Celotex Corp. v. Catrett*, 477 U.S. 317, 324 (1986) (citation omitted).

B. *Application of Standard*

1. *Application of Agency Standard*

Defendant argues that as a matter of law it was not required to entertain plaintiff's application for long-term disability benefits because the application was untimely. Plaintiff argues that he provided timely notice to his employer, MAC, and that under agency law, timely notice to MAC was tantamount to timely notice to UNUM.

First, the court considers the issue of whether agency law is applicable to this case. The MAC plan administered by UNUM is governed by ERISA and ERISA preempts all state law claims "relating to" an ERISA plan. 29 U.S.C. § 1144(a); *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 44 (1987). Plaintiff argues however, that in this instance, state agency law applies. Specifically, plaintiff relies upon *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503 (1967). In *Elfstrom*, the California Supreme Court concluded that where an employer is the named insured under a group insurance policy, the employer acts as an agent of the insured. *Id.* at 513. In reaching this conclusion, the court noted that in performing administrative duties related to the group insurance benefits, the employer was not acting entirely for its own benefit, but for the benefit of both the insurance company and itself. *Id.* at 511. Administrative duties included determination of employee's eligibility for insurance and completing the certificate of insurance. *Id.* at 513-14.

Plaintiff contends that his employer furnished UNUM with information regarding MAC's employees, determined which employees were eligible for coverage and arranged for payments to be made to UNUM. By performing these duties, plaintiff suggests that MAC acted as an agent for UNUM. As such, plaintiff argues that providing notice to the human resources division of MAC constituted timely notice to UNUM.

Defendant contends that in this case, the holding in *Elfstrom* is not applicable because ERISA preempts the field. Plaintiff argues that under the "savings clause," ERISA does not preempt "any law of any State which regulates insurance, banking, or securities." 29 U.S.C. § 1144(b)(2)(A). To determine whether a state provision falls under the "savings clause," the court must determine if the state provision is specifically directed to the insurance industry. *Pilot Life*, 481 U.S. at 48. Whether the law affects the "business of insurance" is further determined by a three-prong test: (1) whether the practice has the effect of spreading a policyholder's risk; (2) whether it is an integral part of the policy relationship between insurer and insured; and (3) whether it is limited to entities within the insurance industry. *Metropolitan Life Ins. Co. v. Mass.*, 471 U.S. 724, 739 (1985).

Here, the court notes that *Elfstrom* does not meet all the necessary criteria. First, the mere fact that an employer acts as an agent for the insurer does not transfer the policyholder's risk. The assumption of administrative duties by the employer does not transfer risk of loss from the insurer to the employer.

Second, the rule in *Elfstrom* is not an integral part of the policy relationship between insurer and insured. As defendant correctly points out, California law allows for limitations to be placed on an agency relationship between employer and insured. Specifically, California Insurance Code § 10209(d) states that "[t]he contract of insurance and individual certificate may contain provisions defining the extent to which the employer acts as the agent of the employee or may act as the agent of the insurer." *Id.* The policy in question here states that MAC "acts on its own behalf or as agent of the employee." It further states that "[u]nder no circumstances will [MAC] be deemed the agent of [UNUM] without a written authorization."

2. *Was Plaintiff's Application for Benefits Timely*

Because *Elfstrom* does not fall under the savings clause exception, the court finds that ERISA controls this case. Under ERISA, the district court reviews de novo a determination of non-eligibility for ERISA benefits. *Patterson v. Hughes Aircraft Co.*, 11 F.3d 948 (9th Cir. 1993). Terms in an ERISA insurance policy are interpreted in "an ordinary and popular sense as would a [person] of average intelligence and experience." *Evans v. Safeco Life Ins.*, 916 F.2d 1437, 1441 (9th Cir. 1991) (per curiam). Courts should not "artificially create ambiguity where none exists." *Id.* Finally, "[i]f a reasonable interpretation favors the insurer and any other interpretation would be strained, no compulsion exists to torture or twist the language of the policy." *Id.*

Under the terms of the Plan, plaintiff had 180 days from the discovery of his disability to file for long-term disability benefits. If it was not reasonable for him to give proof of disability within those 180 days, plaintiff was required to file his claim within one year plus 180 days from the onset of his disability. The policy regarding proof of claim was included in the booklet summarizing benefits which plaintiff found in his safe deposit box.

In his application for benefits, plaintiff states that his disability began on or about May 5, 1992. As such, the latest day for plaintiff to file his claim was December 5, 1993. However, plaintiff did not file his claim until April 11, 1994. Pursuant to the policy, plaintiff's claim was late and therefore defendant was not obligated to honor plaintiff's claim for long-term disability benefits.

Plaintiff claims he relied on MAC's human resources division to provide him with information regarding his benefits. The court notes, however, that plaintiff was not a mere employee of MAC, but served as CEO of the company. As CEO of the company, plaintiff met annually with the company's Human Resources department to review MAC's insurance plan, including the one at issue. Plaintiff states that five months before his termination, he attended a company-wide meeting relating to MAC's benefits. A UNUM representative provided information at that meeting. Thus, the court finds that plaintiff had adequate notice of the types of insurance coverage offered by his company.

Finally, as a point of policy, UNUM aptly notes that the reason for placing a time limit on filing proof of claims is to avoid the prejudicial effect of delay. The Plan extends only to a disability which occurred while plaintiff was working for the company. The delay in filing precludes UNUM from definitively determining whether plaintiff's disability existed on the date alleged in his claim.

CONCLUSION

The court certainly finds the facts of this case to be sympathetic. Nonetheless, having carefully reviewed the matter, the court finds that plaintiff did not file a timely application for benefits. Accordingly, defendant's motion for summary judgment is granted.

IT IS SO ORDERED.

Dated: 8-7-95

/s/ Marilyn L. Huff
MARILYN L. HUFF
Judge
United States District Court

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

Case No. 94-1454 H(AJB)

JOHN E. WARD,

Plaintiff,

vs.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,

Defendant.

Date: July 24, 1995
Courtroom of the Honorable Marilyn L. Huff

DECLARATION OF JOHN A. HOUSER, III

Attached hereto for the Court's convenience is a true and correct copy of the Declaration of John A. Houser III, and the exhibits attached thereto. The original Declaration of Mr. Houser was filed in connection with Defendants' prior Motion for Summary Judgment and is contained in the Court's file.

DATED: June 26, 1995

Respectfully submitted,

JEFFREY P. SMITH
DAVID RIBAKOFF
ADAMS, DUQUE & HAZELTINE

By /s/ Jeffrey P. Smith
JEFFREY P. SMITH
Attorneys for Defendants
UNUM Life Insurance
Company of America and
Management Analysis
Company Plan

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

Case No. 94-1454 H(AJB)

JOHN E. WARD,

Plaintiff,

vs.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,

Defendant.

Date: May 8, 1995
Courtroom of the Honorable Marilyn L. Huff

DECLARATION OF JOHN A. HOUSER, III

I, John A. Houser, III, declare as follows:

1. I am the Director-Technical Services in the Quality Review Section of UNUM Life Insurance Company of America ("UNUM"). The Quality Review Section is responsible for performing ERISA reviews of disability benefits claims such as that of John E. Ward, the plaintiff in this case.

2. The facts set forth herein are based upon my own personal knowledge. My personal knowledge is in part derived from my review of and familiarity with UNUM's records relating to this claim and the subject Group Policy No. 310727 (the "Policy"). Those records are business records of UNUM which were prepared by or received by employees of UNUM in the course of its business at or near the time of the acts, conditions or events described in the records. The records are prepared by persons with

knowledge or from information given by a person with knowledge of the acts, conditions, or events described in the records. The records are kept by UNUM in the course of its regularly conducted business activities, in accordance with its regular practices, and are trustworthy. If called as a witness in this matter, I could and would testify competently thereto.

3. Attached hereto as Exhibit 1 is a true and correct copy of the Group Long Term Disability Policy issued by UNUM Life Insurance Company of America to Management Analysis Corporation ("MAC") under which eligible employees of MAC were covered, including Mr. Ward. This is the Policy which was in effect on May 8, 1992, the date of Mr. Ward's alleged disability. The original effective date of the Policy was November 1, 1993.

4. Attached as Exhibit 2 is a true and correct copy of the employee certificate booklet which summarizes and describes the coverage under the Policy. This is the booklet which was in effect at the time of Mr. Ward's alleged disability. A quantity of these booklets were sent by UNUM to MAC for distribution to MAC's employees.

5. In accordance with terms the Policy, the policyholder (MAC) acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder (MAC) be deemed the agent of the Company (UNUM) without a written authorization. [See, Policy at L-GPP-4] No such written authorization was ever issued by UNUM to MAC.

6. The Policy requires insureds to submit proof of their claims no later than 90 days after the end of the elimination period [Policy at L-GPP-2-L-GPP-3]. "Proof of claim" requires completion of a three part claim form. The first part, to be completed by the insured, is entitled "Application for Long Term Disability Benefits." The second part, to be completed by the employer/policyholder, is entitled "Employer's Report of Claim," and the

third part, entitled "Attending Physician's Statement" is to be completed by the insured's treating physicians.

7. On April 11, 1994, UNUM, through its Western Regional Benefits Office located in Glendale, California, first received notice of Mr. Ward's claim for long term disability benefits under the Policy. UNUM received the following documents pertaining to Mr. Ward's claim, true and correct copies of which are attached hereto:

a. A Long Term Disability Claim Employer's Statement, dated April 6, 1994 [Exhibit 3];

b. A Long Term Disability Claim Job Analysis dated April 6, 1994 [Exhibit 4];

c. Long Term Disability Claim Employee's Authorization dated March 29, 1994 [Exhibit 5];

d. Long Term Disability Claim Employee's Statement dated March 29, 1994 [Exhibit 6];

e. Letter from Maria Bonney dated April 6, 1994 [Exhibit 7];

f. W-2 Wage and Tax Statements 1991 and 1992 for John E. Ward [Exhibit 8];

g. Group Enrollment Request Card of John E. Ward [Exhibit 9];

h. Memorandum from MAC to John E. Ward dated April 5, 1983 Re: Statement of Insurance Coverage Effective Date: 3/21/83 [Exhibit 10];

i. Resume of John E. Ward [Exhibit 11];

j. Award Certificate Letter from Social Security Administration to John E. Ward, dated July 30, 1993 [Exhibit 12];

k. Long Term Disability Claim Physicians Statement of Robert A. Smith dated March 23, 1994 [Exhibit 13];

l. Letter from Christian W. Mende, M.D., F.A.C.P. to Whom it May Concern, dated March 28, 1994 [Exhibit 14];

m. Letter from N.A. Nabavi M.D., F.A.C.S. to Whom it May Concern, dated May 7, 1993 [Exhibit 15];

n. Letter from George A. Curry, II, M.D. to Robert A. Smith, M.D., dated March 24, 1994 entitled Supplemental Report [Exhibit 16];

o. Letter of John E. Ward to Western Regional Benefits, dated March 25, 1994, and accompanying list of attachments [Exhibit 17];

p. Letter of Robert A. Smith, M.D. to Department of Health and Human Services dated April 22, 1993 [Exhibit 18];

q. Radiology Report of David Rabinov, M.D., dated October 29, 1992 [Exhibit 19];

r. Letter of Magid Molaire, M.D. to Nicholas A. Nabari, M.D., dated November 16, 1992 [Exhibit 20];

s. Letter of Magid Molaire, M.D. to Nicholas A. Nabari, M.D., dated November 20, 1992 [Exhibit 21];

t. Letter of N.A. Nabavi, M.D. F.A.C.S. to Robert Smith, M.D. dated November 9, 1992, and enclosures [Exhibit 22];

u. Letter of Donald J. Sage, M.D., F.A.C.S. to Robert Smith, M.D., dated November 30, 1992 [Exhibit 23];

v. Letter of George A. Carey, II, M.D. to Robert A. Smith, M.D., dated April 15, 1993 [Exhibit 24].

8. Prior to the receipt of the aforementioned documents on April 11, 1994, UNUM had no notice or knowledge that Mr. Ward was disabled or that he intended to make a claim under the Policy. UNUM first became aware of Mr. Ward's potential claim on April 11, 1994. Mr. Ward did not submit a claim to UNUM for long term

disability benefits at the time of his alleged disability, which he claimed occurred on May 8, 1992, or at any time prior to April 11, 1994. Accordingly, by letter dated April 13, 1994, UNUM advised Mr. Ward that it was unable to review his application for benefits on the ground that proof of claim had not been submitted within the time frame specified under the Policy. A true and correct copy of UNUM's letter of April 13, 1994 is attached hereto as Exhibit 26.

9. Mr. Ward, through his attorney Brooks L. Iler, requested review of UNUM's claim denial by letter dated June 6, 1994. A true and correct copy of Mr. Iler's letter of June 6, 1994 is attached hereto as Exhibit 27.

10. By letter dated July 12, 1994, UNUM advised Mr. Ward and Mr. Iler that it had completed its review and that its initial determination had been upheld. The ground for UNUM's denial of benefits was that Mr. Ward had not submitted proof of claim within the time limit specified in the Policy in which he was a participant. A true and correct copy of UNUM's July 12, 1994 letter is attached hereto as Exhibit 28.

11. Had plaintiff timely filed his claim for disability benefits under the Policy, UNUM would have conducted a thorough claim investigation. In handling claims for long term disability benefits, it is UNUM's usual and customary practice to request from each of its insured's treating physicians copies of all office/treatment notes, basic laboratory data, test results and consultations for the patient's treatment period to evaluate a claim and to better understand a claimant's medical condition. Additionally, treating physicians are requested to provide UNUM with the patient's current restrictions and limitations, a detailed physical capacity evaluation, prognosis for return to work and the current course of treatment. Depending upon the information received, UNUM may schedule an independent medical examination of the claimant in order to obtain a second opinion regarding

the nature of the claimant's medical condition and disability and may conduct a vocational analysis.

12. Plaintiff submitted his claim to UNUM nearly two years after the onset of his disability. During that nearly two year period, UNUM was without knowledge that plaintiff claimed he was "disabled" and was thereby deprived of the opportunity to fully evaluate his claim and to determine the extent of his disability at the time he claimed to be disabled.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct.

Executed on March 29, 1995, at Portland, Maine.

/s/ John A. Houser, III
JOHN A. HOUSER, III

EXHIBIT 1

[Logo] Unionmutual

Policyholder:

MANAGEMENT ANALYSIS COMPANY

Policy Number: 310727

Policy Effective Date: November 1, 1983 *
* Revised by Amendment No. 05

Premium Due Dates:
January 1 and the first day of each following month.

Governing Jurisdiction: CALIFORNIA

Policy Anniversary:
November 1, 1986, and each following November 1

Unionmutual Stock Life Insurance Co. of America (referred to as the Company) will pay the benefits provided in this policy. The Company makes this promise subject to all of this policy's provisions.

The policyholder should read the policy specifications carefully and contact the Company promptly with any questions.

This policy is delivered in and governed by the laws of the governing jurisdiction.

Signed for the Company at Portland, Maine on the policy effective date.

/s/ [Illegible]
Secretary

/s/ [Illegible]
President

Unionmutual Stock Life Insurance Co. of America
A Stock Life Insurance Company

SECTION VI—GENERAL POLICY PROVISIONS

* * * *

a. information relative to employees:

i. who qualify to become insured;

ii. whose amounts of insurance change; and/or

iii. whose insurance terminates.

b. any other information about this policy that may be reasonably required.

The employer's records which, in the opinion of the Company, have a bearing on the insurance will be opened for inspection by the Company at any reasonable time.

2. Clerical error or omission will not:

a. deprive an employee of insurance;

b. affect an employee's amount of insurance; or

c. effect or continue an employee's insurance which otherwise would not be in force.

E. MISSTATEMENT OF FACTS

If relevant facts about any employee were not accurate:

1. a fair adjustment of premium will be made; and

2. the true facts will decide if and in what amount insurance is valid under this policy.

F. NOTICE AND PROOF OF CLAIM

1. Notice

a. Written notice of claim must be given to the Company within 30 days of the date disability starts, if that is possible. If that is not possible, the Company must be notified as soon as it is reasonably possible to do so.

b. When the Company has the written notice of claim, the Company will send the insured its claim forms. If the forms are not received within 15 days after written notice of claim is sent, the insured can send the Company written proof of claim without waiting for the form.

2. Proof

a. Proof of claim must be given to the Company. This must be done no later than 90 days after the end of the elimination period.

b. If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. But proof of claim may not be given later than one year after the time proof is otherwise required.

c. Proof of continued disability and regular attendance of a physician must be given to the Company within 30 days of the request for the proof.

d. The prof must cover:

i. the date disability started;

ii. the cause of disability; and

iii. how serious the disability is.

G. EXAMINATION

The Company, at its own expense, will have the right and opportunity to have an employee, whose injury or sickness is the basis of a claim, examined by a physician or vocational expert of its choice. This right may be used as often as reasonably required.

H. LEGAL PROCEEDINGS

A claimant or the claimant's authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor
2. more than 3 years after the time proof of claim is required.

I. TIME OF PAYMENT OF CLAIMS

When the Company receives proof of claim, benefits payable under this policy will be paid monthly during any period for which the Company is liable.

J. PAYMENT OF CLAIMS

All benefits are payable to the employee. But if a benefit is payable to an employee's estate, an employee who is a minor, or an employee who is not competent, the Company has the right to pay up to $1,000 to any of the employee's relatives whom the Company considers entitled. If the Company pays benefits in good faith to a relative, the Company will not have to pay such benefits again.

K. WORKERS' OR WORKMEN'S COMPENSATION

This policy is not in lieu of, and does not affect, any requirement for coverage by workers' or workmen's compensation insurance.

L. AGENCY

For all purposes of this policy, the policyholder acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company without a written authorization.

SECTION I— POLICY SPECIFICATIONS

1. Description of Eligible Classes

   Class 1 President, Vice Chairman, Senior Vice President, Division Manager and Vice President

   Class 2 All other employees

2. Amounts of Insurance

   a. The lesser of:

      i. 60% of basic monthly earnings less other income benefits, except family Social Security benefits; or

      ii. 70% of basic monthly earnings, less all other income benefits; or

      iii. the maximum monthly benefit.

      Note: This benefit is subject to reductions for earnings as provided in the Monthly Benefit section of this policy.

   b. The maximum monthly benefit is $13,000.

   c. The minimum monthly benefit is the greater of:

      i. $100.; or

      ii. 10% of the monthly benefit before deductions for other income benefits.

3. Maximum Benefit Period

Age at Disability	Maximum Benefit Period
Less than age 60	To age 65 but not less than 60 months
60	60 months
61	48 months
62	42 months
63	36 months
64	30 months
65	24 months
66	21 months
67	18 months
68	15 months
69 and Over	12 months

4. Elimination Period: 90 days

5. Minimum Requirement for Active Employment:

   For Daily Salaried Consultants, 114 hours per month based on an average of paid hours from the previous 12 months.

   For Daily Salaried Consultants who have been paid a minimum of 2 months but less than 12 months, average will be based on hours paid for months paid.

   For all others: 30 hours per week

6. Definition of Basic Monthly Earnings

   For Daily Salaried Consultants

   "Basic monthly earnings" means 1/12th of salary only from November 1st through October 31st of the year prior to the date salary changes are made. Salary changes will be made January 1st of each year.

   For Daily Salaried Consultants with less than one year of service:

   "Basic monthly earnings" means 1/12th of 171 work days times the employees individual contractual daily work rate.

   For all other employees

   "Basic monthly earnings" means the insured's monthly rate of earnings from the employer in effect just prior to the 12 month period ending on November 1 of each year, actual changes will take effect January 1. It includes earnings from commissions, bonuses and overtime pay, but not other extra compensation.

   Commissions, bonuses and overtime pay will be averaged for the lesser of:

   a. the 12 month period of employment just prior to November 1; or

   b. the period of employment.

7. Waiting Period:

   a. Employees in an eligible class on or before the policy effective date: None

   b. Employees entering an eligible class after the policy effective date: First of the month following date of employment

   The employee must be in continuous active employment in an eligible class during the specified waiting period.

8. Employee Contributions Required: Yes

   Note: Coverage for which contributions are required applies only if proper enrollment is made and the required contributions are made.

9. Divisions, Subsidiaries or Affiliated Companies included

Name	Location (City and State)
Pacific Atlantic Technical Services, Inc.	Atlanta, GA
MACTEC	San Diego, CA

10. Changes Effective

    Subject to the Delayed Effective Date subsections, changes in insurance take effect each November 1.

11. Continuation of Employee Insurance During Absences

Type of Absence	Time Limit
Temporary Layoff or Leave of Absence	To the end of the 3 month period following the policy month in which the layoff or leave of absence begins.

SECTION II—DEFINITIONS

For the purposes of this policy:

"Active employment" means the employee must be working:

1. for the employer on a permanent full-time basis and paid regular earnings;
2. at least the minimum number of hours shown in the policy specifications; and either
3. at the employer's usual place of business; or
4. at a location to which the employer's business requires the employee to travel.

"Basic monthly earnings"—As defined in the policy specifications.

"Certificate" means a written statement prepared by the Company including all riders and supplements, if any, setting forth a summary of:

1. the insurance benefits to which an employee is entitled;
2. to whom the benefits are payable; and
3. limitations or requirements that may apply.

"Complications of pregnancy" means pregnancy complicated by concurrent disease or abnormal conditions significantly affecting usual medical management.

"Disability" or "disabled"—see last page of Section II.

"Disability benefits," when used with the term retirement plan, means money which:

1. is payable under a retirement plan due to disability as defined in that plan; and

2. does not reduce the amount of money which would have been paid as retirement benefits at the normal retirement age under the plan if the disability had not occurred. (If the payment does cause such a reduction, it will be deemed a retirement benefit as defined in this policy.)

"Eligibility date" means the date an employee becomes eligible for insurance under this policy. Classes eligible are shown in the policy specifications.

"Elimination period" means a period of consecutive days of disability for which no benefit is payable. The elimination period is shown in the policy specifications and begins on the first day of disability.

Note: If disability stops during the elimination period for any 7 (or less) days, then the disability will be treated as continuous. But days that the insured is not disabled will not count toward the elimination period.

"Employee" means a person in active employment with the employer.

"Employer" means the policyholder and includes any division, any subsidiary or any affiliated company named in the policy specifications.

"Evidence of insurability" means a statement or proof of an employee's medical history upon which acceptance for insurance will be determined by the Company.

"Grace period" is the 31 days folowing a premium due date during which premium payment may be made.

"Gross monthly benefit" means the insured's benefit amount before any reduction for other income benefits and earnings.

"Home office" means the Unionmutual Stock Life Insurance Co. of America, 2211 Congress Street, Portland, Maine 04122.

"Indexed pre-disability earnings" means the insured's basic monthly earnings in effect just prior to the date his disability began adjusted by 7% on the first anniversary of benefit payments and each following anniversary to a maximum of 5 adjustments.

"Injury" means bodily injury resulting directly from an accident and independently of all other causes. The injury must occur and disability must begin while the employee is insured under this policy.

"Insured" means an employee insured under this policy.

"Male pronoun" whenever used includes the female.

"Monthly Benefit" means the amount payable by the Company to the disabled insured.

"Partial disability" or "partially disabled"—see last page of Section II.

"Physician" means a person who is:

1. operating within the scope of his license; and either
2. licensed to practice medicine and prescribe and administer drugs or to perform surgery; or
3. legally qualified as a medical practitioner and required to be recognized, under this policy for insurance purposes, according to the insurance statutes or the insurance regulations of the governing jurisdiction.

It will not include an employee or his spouse, daughter, son, father, mother, sister or brother.

"Policy Specifications" is the document showing the eligible classes, the amounts of insurance and other relevant information pertaining to the plan of insurance applied for by the policyholder. This document, designated Section I, is attached to and is part of this policy.

* * * *

MAC

MANAGEMENT ANALYSIS COMPANY

Your Long Term Disability Income Benefits

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CERTIFICATE OF COVERAGE

This certificate does not apply unless this space is covered by sticker form 100-77

UNUM Life Insurance Company of America (referred to as "we," "our" and "us") welcomes your employer as a client.

This is your certificate of coverage as long as you are eligible for insurance and you become and remain insured. Keep it in a safe place.

A few words about this certificate of coverage. . . .

We have written it in plain English. But a few terms and provisions are written as required by insurance law. You will want to read it carefully. If you have any questions about any terms and provisions, please contact the Insurance Administrator at your work location or write to our claims paying office. We will assist you in any way we can to help you understand your benefits.

Also, if the terms of your certificate of coverage and the policy differ, the policy will govern. Your coverage may be terminated or modified in whole or in part under the terms and provisions of the policy.

/s/ Jerry F. Orr, III

President

PLAN OUTLINE

Description of Eligible Classes

President, Vice Chairman, Senior Vice President, Division Manager and Vice President

Amount of Insurance

- The lesser of:
  1. 60% of basic monthly earnings less other income benefits, except family Social Security benefits; or
  2. 70% of basic monthly earnings, less all other income benefits; or
  3. the maximum monthly benefit.

     Note: This benefit is subject to reductions and earnings as provided in the section titled "How is the benefit figured?"
- The maximum monthly benefit is $13,000.
- The minimum monthly benefit is the greater of:
  1. $100.00; or
  2. 10% of the monthly benefit before deductions for other income benefits.

CONVERSION PRIVILEGE

Under what conditions can you convert?

When your insurance under this plan terminates because you end employment with the policyholder, you may obtain converted disability income coverage without medical evidence of insurability. But you must have been insured for at least twelve consecutive months just before your insurance under this plan terminated. These twelve months will be considered to include the time you were

insured for group long term disability under both this plan and the one it replaced, if any.

Who may not convert?

The conversion privilege is not available to you if:

1. your insurance under this plan terminates for any of the following reasons:
   a. this plan terminates;
   b. this plan is amended to exclude from coverage the class of employees to which you belong;
   c. you no longer belong to a class of employees eligible for coverage under this plan;
   d. you retire;
   e. you failed to pay any required premium;
2. you are or become insured for long term disability insurance under another group plan within 31 days after termination; or
3. you are disabled under the terms of this plan.

When must you apply for the conversion coverage?

You must apply for and pay the first quarterly premium for the conversion coverage within 31 days after your insurance terminates under this plan.

Is the conversion coverage the same as that provided under this plan?

The Company governs the form of coverage, the benefits and the amounts. The benefit and amounts may differ from those under this plan.

SOME GENERAL INFORMATION TO KNOW

When must we be notified of a claim?

You must give us written notice of claim within 30 days of the date disability starts. If that is not possible, you must notify us as soon as you can.

When we receive your written notice of claim, we will send you our claim forms. If you do not receive the forms within 15 days after you sent the notice, you can send written proof of claim without waiting for the form.

When does proof of claim have to be given?

You must give us proof of claim no later than 90 days after the end of the elimination period.

If it is not possible for you to give proof within these time limits, it must be given as soon as reasonably possible. But you may not give proof later than one year after the time it is otherwise required.

You must give us proof of continued disability and regular attendance of a physician within 30 days of the date we request the proof.

The proof must cover:

1. the date disability started;
2. the cause of disability; and
3. how serious the disability is.

When are claims paid?

When we receive proof of claim, benefits payable under the policy will be paid monthly during any period for which we are liable.

Who are claims paid to?

All benefits are payable to you. But if a benefit is payable to your estate, or if you are a minor, or you are not competent, we have the right to pay up to $1,000 to any of your relatives whom we consider entitled. If we pay bene-

fits in good faith to a relative, we will not have to pay such benefits again.

What are our examination rights?

We, at our expense, have the right and opportunity to have you examined by a physician or vocational expert of our choice to determine the extent of any sickness or injury for which you have made a claim. This right may be used as often as reasonably required.

How can statements made in any application for this insurance be used?

In the absence of fraud, all statements you made when applying for this insurance and providing evidence of insurability are considered representations and not warranties (absolute guarantees). No statements by you will be used to reduce or deny a claim:

1. after 2 years from your most recent effective date of insurance; and

2. unless a copy of your statements has been given to you.

Can legal proceedings be stated at any time?

No, you or your authorized representative cannot start any legal action:

1. until 60 days after proof of claim has been given; nor

2. more than 3 years after the time proof of claim is required.

What happens if facts are misstated?

If relevant facts about you were not accurate:

1. a fair adjustment of premium will be made; and

2. the true facts will decide if and in what amount insurance is valid.

Does this coverage affect workers' or workmen's compensation?

The policy is not in lieu of, and does not affect, any requirement for coverage by workers' or workmen's compensation insurance.

SUMMARY PLAN DESCRIPTION

Name of Plan:

MANAGEMENT ANALYSIS COMPANY

Policy No.: 310727

Participants Included: See Plan Outline
Name and Address of Employer
MANAGEMENT ANALYSIS COMPANY
12671 High Bluff Drive
San Diego, California 92130

Who Pays For the Plan: The cost of the plan is shared by both you and your employer.

Plan Identification Number

a. Employer IRS Identification No.: 95-3139094

b. Plan No.: 000503

Plan Year: January 1

Plan Administrator, Name, Address and Telephone No.
MANAGEMENT ANALYSIS COMPANY
12671 High Bluff Drive
San Diego, California 92130
(619) 452-5000

Agent for Service of Legal Process on the Plan
Same as above

Loss of Benefits

On any premium due date the policyholder may terminate the policy(ies) or, subject to the insurance company's approval, may modify, amend or change the provisions, terms and conditions of the policy(ies). No consent of any participant or any other person referred to in the policy(ies) shall be required to terminate, modify, amend, or change the policy(ies).

NOTE: If you cease active employment, see your supervisor to determine what arrangements, if any, may be made to continue your coverage beyond the date you cease active employment.

What are your rights in the event of plan termination?

Termination of this policy under any conditions will not prejudice any payable claim which occurs while this plan is in force.

When may the plan terminate?

1. If the policyholder fails to pay any premium within the grace period, this policy will automatically terminate at 12:00 midnight of the last day of the grace period. The "grace period" is the 31 days following a premium due date during which premium payment may be paid.

2. The policyholder may terminate this policy by advanced written notice delivered to the insurance company at least 31 days prior to the termination date. But this policy will not terminate during any period for which premium has been paid.

3. The insurance company may terminate this policy on any premium due date by giving written notice to the policyholder at least 31 days in advance if:
   a. The number of employees insured is less than 10; or

   b. Less than 100% of the employees eligible for any noncontributory insurance are insured for it; or
   c. Less than 75% of the employees eligible for any contributory insurance are insured for it; or
   d. The policyholder fails:
      i. To furnish promptly any information which the insurance company may reasonably require; or
      ii. To perform any other obligations pertaining to this policy.

4. Termination may take effect on any earlier date when both the policyholder and the insurance company agree.

What are your rights under ERISA?

1. As a participant in this plan, you are entitled to certain rights and protection under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:
   a. Examine, without charge, at the Plan Administrator's office and at other specified locations, all Plan documents including insurance contracts, and copies of all documents filed by the Plan with the U. S. Department of Labor, such as detailed annual reports and plan descriptions.
   b. Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. The Plan Administrator may make a reasonable charge for the copies.
   c. Receieve a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

2. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.

3. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

4. No one, including your employer, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

5. If your claim for a benefit is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

6. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $100 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

7. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a federal court. The

court will decide who should pay court costs and legal fees. If you are successful the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

8. If you have any questions about your Plan, you should contact the Plan Administrator.

9. If you have any questions about this statement or about your rights under ERISA, you should contact the nearest Area Office of the U. S. Labor-Management Services Administration, Department of Labor.

What if your claim is denied?

In the event that your claim is denied, either in full or in part, the insurance company will notify you in writing within 90 days after your claim form was filed. Under special circumstances, the insurance company is allowed an additional period of not more than 90 days (180 days in total) within which to notify you of its decision. If such an extension is required, you will receive a written notice from the insurance company indicating the reason for the delay and the date you may expect a final decision. The insurance company's notice of denial shall include:

1. The specific reason or reasons for denial with reference to those policy provisions on which the denial is based;

2. A description of any additional material or information necessary to complete the claim and an explanation of why that material or information is necessary; and

3. The steps to be taken if you or your beneficiary wish to have the decision reviewed.

Please note that if the insurance company does not respond to your claim within the time limits set forth above, you should automatically assume that your claim has been denied and you should begin the appeal process at that time.

What do you do to appeal?

You, the claimant, or your authorized representative may appeal a denied claim within 60 days after you receive the insurance company's notice of denial. You have the right to:

1. Submit a request for review, in writing, to the insurance company;

2. Review pertinent documents; and

3. Submit issues and comments in writing to the insurance company.

The insurance company will make a full and fair review of the claim and may require additional documents as it deems necessary or desirable in making such a review. A final decision on the review shall be made not later than 60 days following receipt of the written request for review. If special circumstances require an extension of time for processing, you will be notified of the reasons for the extension, and a decision shall be made not later than 120 days following receipt of the request for review. The final decision on review shall be furnished in writing and shall include the reasons for the decision with reference, again, to those policy provisions upon which the final decision is based.

Plan Arranged by
FINANCIAL ADVISORY SERVICES
12555 High Bluff Dr.
Suite 333
San Diego, CA 92130

[Logo] UNUM

Underwritten by
UNUM Life Insurance Company of America
Portland, Maine

MAC

Management Analysis Company
12671 High Bluff Drive, San Diego, CA 92130
Mail: P.O. Box 85404, San Diego, CA 92186-5404
619-481-3100
FAX: 619/259-5070

April 6, 1994

UNUM
Western Regional Benefits
101 North Brand Blvd.
Suite 800
Glendale, CA 91203

Dear Sir:

Attached is a Long Term Disability claim for John E. Ward. As part of his claim, I am sending you a copy of his 1991 and 1992 W-2, a copy of his LTD enrollment (Mutual Benefit Life Insurance Company was the carrier at the time), and a copy of his most recent resume since no job description is available.

Please contact me at 619-259-5035 if there is any other information you need.

Sincerely,

/s/ Maria Bonney
MARIA BONNEY
Human Resources Supervisor

Attachments

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA
Case No. 94-1454H (AJB)

JOHN E. WARD,
Plaintiff,

vs.

MANAGEMENT ANALYSIS COMPANY
EMPLOYEE DISABILITY BENEFIT PLAN,
Defendant.

Date: July 24, 1995

Courtroom of the Honorable Marilyn L. Huff

DECLARATION OF DEXANA MACQUARRIE

I, Dexana MacQuarrie, declare as follows:

1. I am Vice-President of Human Resources of Management Analysis Company ("MAC") and have been employed with MAC since October 1978. I have held my current position for the last four years. The facts stated in this declaration are personally known to me and, if called as a witness, I could and would testify competently about these facts.

2. As Vice-President of Human Resources, my duties currently include, and have always included, overseeing the operations of MAC's Human Resources department.

3. During the time that John E. Ward was President and CEO of MAC, I met with Mr. Ward annually to review all of BAC's insurance plans, including its long-term disability plan underwritten by UNUM (the "MAC

Plan"). Based upon these meetings, Mr. Ward and I would choose MAC's various insurance plans each year and submit them to MAC's Board of Directors for approval.

4. MAC's Human Resources department relied upon each of the insurance carriers and their respective policy documents to inform us about the procedures for submitting claims. In overseeing the operations of MAC's Human Resources department, I ensured that MAC followed the procedures set forth in the respective plan booklets, including the MAC Plan.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 26, 1995, at Golden, Colorado.

/s/ Dexana MacQuarrie
DEXANA MACQUARRIE

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

Case No. 94-1454H (AJB)

JOHN E. WARD,
Plaintiff,
vs.
MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,
Defendant.

Date: July 24, 1995

Courtroom of the Honorable Marilyn L. Huff

DECLARATION OF MARIA E. BONNEY

I, Maria E. Bonney, declare as follows:

1. I was an employee of Management Analysis Company ("MAC") for approximately ten years, from 1984 through 1994. I was the supervisor of Human Resources at MAC for approximately four years, from 1990 to November 17, 1994. Prior to that position, I was an employment administrator at MAC for approximately two years and prior to that position, I was a project assistant for four years. The facts stated in this declaration are personally known to me and, if called as a witness, I could and would testify competently about these facts.

2. During my four years as supervisor of Human Resources at MAC, the Human Resources department was

responsible for enrolling MAC employees in MAC's insured benefit plans, such as health insurance, life insurance and long-term disability insurance. Human Resources sent enrollment form to its employees who were eligible for these benefits. After the enrollment process was completed, a report would be generated and sent to UNUM listing the enrolled MAC employees for, among other things, long-term disability ("LTD") coverage. A check or checks would also be sent to the insurer each month, representing payment of premiums for the enrolled employees. Employees who enrolled for LTD coverage paid the entire amount of their premiums. The premiums would be deducted from and reflected on the employees' paychecks. Human Resources also monitored the amount of paid leave, sick leave and vacation time MAC employees took and had some responsibility for MAC's ESOP, 401(k) plan and Section 125 plan.

3. During each of my four years as supervisor of Human Resources at MAC from 1990 through 1994, MAC's long-term disability ("LTD") plan was underwritten by UNUM Life Insurance Company of America ("UNUM") and was called the Management Analysis Company Plan (the "MAC Plan"). We relied upon UNUM and the MAC Plan's documents to advise us regarding LTD claims procedures under the MAC Plan.

4. As a matter of course, MAC Plan certificates were issued to all participating MAC employees, including the then President and CEO of MAC, Mr. John E. Ward.

5. While I was the supervisor of Human Resources at MAC, I assisted MAC employees in submitting LTD claims to UNUM on five occasions. One of those claims was the claim submitted by Mr. Ward in April of 1994.

6. There are three parts to a UNUM LTD claim. The employee completes the Application for Disability Benefits and the Authorization. The attending physician completes the Attending Physician's Statement. The employer completes the Employer's Statement of Claim.

7. It was always my understanding that claims were not submitted until they were submitted to UNUM. In each of the five instances when I assisted MAC employees in submitting to UNUM, I advised those employees, including Mr. Ward, that their claims were not submitted until they were submitted to UNUM.

8. I assisted four MAC employees, in addition to Mr. Ward, with their LTD claims under the MAC Plan. In two instances, I simply sent the claims forms to the employees, and they, in turn, submitted their applications directly to UNUM. In another instance, the employee received his application directly from UNUM and submitted it directly to UNUM; I had very little involvement in assisting him. I separately sent the Employer's Report to UNUM in each of these three instances. In another instance, I provided the employee's wife with an application. The completed application was sent back to me by the employee's wife and I forwarded the application and the Employer's Report to UNUM.

9. When Mr. Ward first requested an LTD application from me in late March 1994, I advised him that his claim would be untimely under the time frame set forth in the MAC Plan. Mr. Ward acknowledged his understanding that the deadline for submitting claims under the terms of the MAC Plan had passed, but stated that he wanted to file a claim anyway.

10. I understood from my reading of the MAC Plan's documents that, without a written authorization, MAC was not the agent of UNUM. Rather, MAC acted on its own behalf or on behalf of MAC employees in submitting claims to UNUM. At no time during my employment as supervisor of Human Resources at MAC, did MAC ever receive written authority to act as the agent of UNUM.

11. I have reviewed Mr. Ward's declaration of April 24, 1995. Paragraph 4 of that declaration is incorrect. I never had a telephone conversation with Mr. Ward in August or September of 1992. The first time I spoke with Mr. Ward regarding his available LTD benefits was in early 1994. At that time, Mr. Ward called me and asked whether he had benefits. After I checked his employment file, I told Mr. Ward that he was enrolled in the MAC Plan at the time of his employment with MAC. I did not have any conversation with Mr. Ward regarding the MAC Plan or Mr. Ward's disability until early 1994.

I declare under penalty of perjury that the foregoing is true and correct.

Executed on June 26, 1995, at San Diego, California.

/s/ Maria E. Bonney
MARIA E. BONNEY

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF CALIFORNIA

Case No. 94-1454H (AJB)

JOHN E. WARD,
Plaintiff,

v.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,
Defendant,

DEPOSITION OF JOHN E. WARD

San Diego, California

May 31, 1995

* * * *

Q. Well, didn't you reviewe all of the plans on an annual basis with the vice president in charge of administration?

A. Yes.

Q. And during this time period you were president, were you aware that MAC had a long-term disability plan available for its employees?

A. I think the answer is generally yes. I relied heavily upon the human resource manager to manage the details of all of our programs. And, as I mentioned, I became deeply involved in the health care program because of the costs. We were essentially self-insured.

Q. In 1989 what health care plan did you have in place at that time?

A. I don't remember. I don't remember who was the carrier at that time.

Q. Do you recall the carrier in 1992, at the time that you terminated employment?

A. I do not remember who its was. We frequently changed because of the economic aspects.

O. During the time that you were president, did you have the final say as to what benefit plans would be offered to MAC employees?

A. The approval process was normally that the vice president of support services—that was the right title—would make a recommendation to me. I would, if I approved, which I normally did, would present it to the board of directors, and they'd be accepted by the board.

* * * *

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

Case No. 95-1454H (AJB)

JOHN E. WARD,
Plaintiff,

v.

MANAGEMENT ANALYSIS COMFANY EMPLOYEE DISABILITY BENEFIT PLAN
Defendant.

DEPOSITION OF DEXANA MACQUARRIE

San Diego, California

March 7, 1995

* * * *

Q. Had you ever read that booklet?

A. No.

Q. Did you attend a meeting in late 1991 or early 1992 regarding disability benefits?

A. I attended the employee meeting that we had on the overall benefits program, yes.

Q. That was a poorly worded question. You attended that meeting. Do you recall whether or not there was a presentation regarding disability benefits at that meeting.

A. Yes, there was.

Q. And who gave that presentation, if you know?

A. The UNUM representative.

O. Do you remember who that was?

A. I'm sorry. I don't. It's a sales rep.

Q. Do you remember what the presentation consisted of?

A. It was a summary of the benefit, and I think it was very brief and just summarized what the benefits to the plan were and that it was totally voluntary on the employees' part, paid for by the employees and the value of it.

Q. Do you know if Mr. Ward attended that meeting?

A. Yes, he did.

Q. Do you know if he was there during the presentation of the disability portion of the meeting by the UNUM rep?

A. Yes, he was.

Q. Prior to this were the employees advised who was eligible and who wasn't eligible, or was just everybody invited?

A. To the meeting?

Q. Yes.

A. Everyone was invited.

Q. As of mid-1992, do you have an estimate of how many people were participating in the disability portion of the plan?

A. No.

Q. Do you have an estimate of how many people were eligible to participate?

A. As of mid-'92?

Q. Right.

A. 400.

Q. That's your best estimate?

A. Yes.

Q. Is there any writing that describes your job description at it existed in mid-1992?

A. No.

Q. When did you first become aware that Mr. Ward was going to leave the company?

A. May 1992.

Q. How did you become aware of that?

A. I don't recall who told me.

• • • •

[Filed Sep. 19, 1994]

UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF CALIFORNIA

Case No. 941454H (AJB)

JOHN E. WARD,

Plaintiff,

v.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN,

Defendant.

COMPLAINT TO RECOVER BENEFITS AND FOR DECLARATION OF BENEFITS; REQUEST FOR JURY

(29 U.S.C. 1132)

Plaintiff JOHN E. WARD alleges as follows:

1. Jurisdiction of this Court arises out of and is based upon Section 502 of the Employee Retirement Income Security Act of 1974 ("ERISA") and also arises under 18 U.S.C. 1132.

2. The plaintiff, JOHN E. WARD, is a qualified and vested participant of the MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN ("the Plan") which is an employee disability insurance benefit plan established pursuant to and in accordance with the provisions of ERISA as set forth in 18 U.S.C. 1001, et seq.

3. The Plan is administered by Management Analysis Company. ("MAC"). Both the Plan and MAC have an office and regular place of business in San Diego, California.

4. Plaintiff was an employee of MAC continuously from March 21, 1983 until he became permanently disabled on or about May 5, 1992.

5. The Plan consists of disability insurance coverage underwritten by UNUM Life Insurance Company of America. ("UNUM").

6. MAC adopted the Plan effective November 1, 1983.

7. Plaintiff has duly complied with all conditions necessary to receive disability benefits as described in the Plan.

8. On or about May 5, 1992 plaintiff learned that he was permanently disabled. This was a factor in his decision to retire on May 10, 1992.

9. On or before March 30, 1993 plaintiff advised Dexana G. MacQuarrie, MAC's employee benefits administrator ("Administrator") that he was permanently disabled and would no longer be able to continue any regular employment. Plaintiff requested assistance from Administrator in obtaining benefits under various employee benefit plans administered by MAC, including but not limited to application for extended health insurance benefits due to his total disability and recovery of certain retirement benefits provided by MAC under an employee retirement benefit plan. Plaintiff relied on the Administrator to advise and aid him in protecting any and all rights and recovering any and all benefits available to plaintiff under any MAC employee benefit plans as a result of plaintiff's disability.

10. At all times herein relevant, the Administrator was acting as an agent of UNUM in performing the functions necessary to administer the disability insurance provided by the Plan. Therefore, notice of plaintiff's permanent disability constituted notice to UNUM for purposes of making a claim for disability benefits under the Plan.

11. On or about April 6, 1994, despite having previously provided notice of his permanent disability to

UNUM's agent, Administrator, plaintiff made a written claim for disability benefits directly to UNUM. (Ex. 1.)

12. On or about April 13, 1994 UNUM denied plaintiffs' claim for disability benefits under the Plan, stating that no timely claim therefore had been made. (Ex. 2.).

13. On or about June 6, 1994 plaintiff timely filed his appeal of UNUM's denial of benefits to UNUM Ltd. Quality Review Section pursuant to the administrative procedures set forth in UNUM's benefits denial letter and disability insurance policy. Plaintiff therein set forth citations to legal authority holding that the Administrator is the agent of the insurer for purposes of employee benefits plans regulated by ERISA. Plaintiff also renewed his demand for benefits under the Plan. (Ex. 3.).

14. On or about July 12, 1994 UNUM again denied benefits to plaintiff under the disability Plan. (Ex. 4.).

15. Plaintiff has now exhausted any and all available administrative remedies with respect to this claim for disability benefits under the Plan.

16. The denial of plaintiff's claim to rights and benefits under the Plan was arbitrary, unreasonable and not supported by law.

17. An actual controversy has now arisen between plaintiff and defendant regarding the parties' rights and liabilities under the Plan. Plaintiff desires a judicial determination of those rights and duties under the Plan.

18. As a direct and proximate result of the Plan's failure and refusal to provide disability benefits under the Plan, plaintiff has sustained damages in an amount not now certain. On information and belief, plaintiff alleges that he has sustained, and will continue to sustain damages equal to the amount of benefits due plaintiff in accordance with the disability insurance policy provided by the Plan in an amount not less than $13,000.00 per month for a period of 42 months commencing from the onset of

his disability. Plaintiff alleges that he will continue to sustain similar damage until such time as plaintiff is no longer disabled or until the full benefits under the policy are paid.

19. As a further direct and proximate result of defendant's failure and refusal to provide benefits under the Plan, plaintiff has incurred and will continue to incur attorneys' fees in an amount not yet certain.

WHEREFORE, plaintiff requests judgment against the Plan as follows:

1. Declaring that plaintiff's claim for benefits under the Plan is not barred for untimeliness;

2. Awarding plaintiff a money judgment for all accrued disability benefits under the Plan which are due and owing at the time of judgment;

3. Declaring that plaintiff will continue to be entitled to collect disability benefits under the Plan until such time as he is no longer disabled or until full benefits have been paid pursuant to the Plan.

4. Awarding plaintiff prejudgment interest from May 5, 1992 until the date of judgment.

5. Awarding plaintiff attorneys' fees, court costs and other reasonable costs incurred.

6. For such other and further relief as the court may deem just and proper.

DATED: 9/15/94

SHAFFMAN, ILER, PALKOWITZ & DOFT

By: /s/ Brooks L. Iler
BROOKS L. ILER
Attorney for plaintiff

DEMAND FOR JURY TRIAL

Pursuant to Federal Rules of Civil Procedure, rule 38, plaintiff hereby demands a trial by jury in this action.

DATED: 9/15/94

SHAFFMAN, ILER, PALKOWITZ & DOFT

By: /s/ Brooks L. Iler
BROOKS L. ILER
Attorney for plaintiff

UNUM.

Long Term Disability Claim
Employer's Statemen

To Be Completed By The Employer

This claim is for (Employee's Name)	Social Security Number	Date of Birth
John E. Ward -	565-32-1294	4/24/30

A. Information about the employer

Company's Name	Group Policy Number
Management Analysis Company	0310727-001-3
Address (Street, City, State, Zip)	Telephone: (619) 259-5035
12671 High Bluff Drive , San Diego, CA 92130	Fax: (619) 259-5046

Name and address of division where employee works (if different from above)

B. Information about the employee

Date employee was hired (Month, Day, Year)	Date employee became insured under this plan?	What was the employee's regularly schedule work week?
3/21/83	3/21/83	40 hours per week

C. Information needed for withholding and reporting taxes

Does employee contribute post-tax dollars toward the premium? ☒ Yes ☐ No If yes, what percent is paid by the employee? 100 %
If you leave this section blank, we will assume it is 100% employer contribution and calculate FICA taxes accordingly.

D. Information about the claim

Were there any changes to the employee's job responsibilities due to the disabling condition before the employee became fully disabled?
☐ Yes ☒ No If yes, what were the changes and when were they made?

What was the employee's permanent job on his or her last day at work?	How long had the employee been in this job?
President/CEO	7/6/87 - 3/8/92

Last day employee actually worked (Month, Day, Year)	On that day, did the employee work a full day?
~~3/8/92~~ May 8, 1992 mdw	☒ Yes ☐ No If no, how many hours were worked?

Why did employee stop working?	Is the employee's condition work related?
Board of Directors requested his resignation	☐ Yes ☒ No

Has a claim been filed with Worker's Compensation?
☐ Yes ☒ No If yes, send initial report of illness or injury and award notice.

Name and Address of your compensation carrier
n/a

Name and Address of your medical insurance carrier
n/a

E. Information about your pension plan (do not complete for maternity claim)

Do you have a pension plan?	If yes, what type?			
☒ Yes ☐ No	☐ Defined benefit	☒ 401(k)	☒ Other: (specify)	ESOP
	☐ Defined contribution	☐ Profit sharing		

Is the employee eligible for your pension plan?	If eligible, does the employee participate?
☒ Yes ☐ No If no, why?	☒ Yes ☐ No If no, why?

If the employee is participating, when is he or she eligible for benefits under the plan? (Month, Day, Year)
401(k) - received entire account balance 7/92 ESOP - will receive 5 payments over 5 years

F. Information about your rehire or return-to-work policies

Does your company have a rehire or return-to-work policy for disabled employees?
☐ Yes ☒ No

What is the name and title of the manager we should contact if we identify a rehabilitation or return-to-work option?

G. Information about the employee's salary

The employee (Check all that apply)
☐ is paid hourly (what is the hourly rate?) $ _____ ☒ is salaried ☐ receives commissions ☐ receives bonuses

Is employee file for disability benefits provided by any employer/employee labor management, state disability or union welfare plan?
☒ Yes ☐ No If yes, what is the weekly amount? $ 336 When do benefits begin? 3/10/93 End? ?

Is this employee eligible for salary continuation?
☐ Yes ☒ No If yes, what is the weekly amount? $ _____ When do benefits begin? _____ End? _____

(Continued on Reverse)

BEST AVAILABLE COPY

eporting the employee's basic monthly earnings (For assistance, call the benefits office 800 number shown on the inside front cover of this form)

nd the definition of basic monthly earnings that matches your contract for this employee and follow the instructions given.

efinitions of Basic Monthly Earnings

salary only (no commissions, bonuses, etc.), complete question 1 below
previous year's W-2 form, complete question 5 below (attach W-2)
sole proprietor, complete question 8 below
previous year's K-1 form, complete question 6 below (attach K-1)

. salary and commissions, complete questions 1 and 3 below
salary, commissions and bonuses, complete questions 1, 3 and 4 below
salary and deferred compensation, complete questions 1 and 2 below
salary, deferred compensation and commissions, complete questions 1, 2, and 3 below
salary, deferred compensation, commissions and bonuses, complete questions 1, 2, 3, and 4 below
salary and K-1 earnings, complete questions 1 and 6 below

. W-2 with deferred compensation, complete questions 2 and 5 below
partnership agreement, complete question 7 below
. teacher's contract, complete question 1 below
. any other definition, complete question 9 below

84a

) On the last day the employee worked, what was his or her basic monthly salary?
(Divide annual salary by 12 or multiply weekly salary by 52 and divide by 12. Teachers divide annual salary by 12) 1 $19,583.33

) On the last day the employee worked, what was his or her monthly pre-tax contribution to your deferred compensation plan? 2 n/a

) How much had the employee received in commissions in the 12 months (or the period of employment if less than 12 months) immediately preceding the last day worked? $ _____.
Divide this number by 12, or the length of employment if less than 12 months, to find the average monthly commissions. 3 n/a

) How much had the employee received in bonuses in the 12 months (or the period of employment if less than 12 months) immediately preceding the last day worked? $ _____.
Divide this number by 12, or the length of employment if less than 12 months, to find the average monthly bonuses. 4 _____

) What were the employee's earnings as shown on the W-2 form of the year immediately preceding the disability? 1991 5 $232,553

) What were the employee's earnings as shown on the K-1 form of the year immediately preceding the disability? 6 n/a

) As of the last day the employee worked, what were the budgeted annual earnings as determined by the written partnership agreement in effect? (Do not include dividends, interest or return of capital) $ _____. 7 n/a

) As of the last day the employee worked, what was the sole proprietor's annual net profit (1040 Schedule C gross income minus total deductions minus depreciation) averaged over the 3 years immediately preceding the disability or the period of sole proprietorship if less than 3 years? 8 n/a

) For definitions other than those above, calculate the monthly earnings as they are defined in your contract. If earnings are based on salary as expressed on a particular document, send us a copy of the document. 9 n/a

. Required Attachments and Signature

the employee contributes to the premiums, attach a copy of the enrollment form.
salary is based on a W-2, K1, 1099, or a similar document, attach a copy of the document.
you have medical information from the employee's file relating to this disability, please attach copies.
a worker's compensation claim is filed, send initial report of injury or illness and award notice.

ame of person completing this form (If this claim is approved for disability benefits, the benefit check will be sent to the employee with a carbon copy to you.)

Maria Bonney

7

Maria Bonney — Signature
Human Resources Supervisor — Title
4/6/94 — Date

) UNUM.

Long Term Disability Claim
Job Analysis

e Completed By The Employee's Supervisor

(Claim is for (Employee's Name)

John E. Ward

Employee's Social Security Number: 565-32-1294

Date of Disability (Month, Day, Year): Social Security determination 5/10/92

General information about the employee's job

Title: President/CEO

Minimum education or training required: B.S. or B.A.

Does the employee perform supervisory functions?
☒ Yes ☐ No If yes, how many people are supervised? entire staff - 500 Describe job duties.

CEO for management consulting firm

Check the items below that relate to the employee's job. Use these definitions for the frequency of occurrence:
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

	Occasionally	Frequently	Continuously
ate to others	☐	☐	☒
tten and verbal communication	☐	☒	☐
asoning, math and language	☐	☐	☒
akes independent judgments	☐	☐	☒

Which of the following describe the employee's working environment? Check all that apply.
☐ Unprotected heights ☐ Changes in temperature or humidity ☐ Exposure to dust, fumes and gases
☐ Being near moving machinery ☒ Driving automotive equipment ☐ Other hazards

Is the employee required to travel?
☒ Yes ☐ No If yes, complete the following information:

How does the employee travel? (Automobile, plane, train, etc.)	Where does the employee travel?	What percent of the time does the employee travel?
auto, plane, train	U.S. and occasionally overseas	25%

Information about the physical aspects of the employee's job

Check the items below that relate to the employee's job and complete the information requested. Use these definitions for the frequency of occurrence:
Occasionally means the person does the activity up to 33% of the time.
Frequently means the person does the activity 34% to 66% of the time.
Continuously means the person does the activity 67% to 100% of the time.

Activity	Occasionally	Frequently	Continuously
☒ Standing	☐	☒	☐
☒ Walking	☐	☒	☐
☒ Sitting	☐	☒	☐
☐ Balancing	☐	☐	☐
☐ Stooping	☐	☐	☐
☐ Kneeling	☐	☐	☐
☐ Crouching	☐	☐	☐
☐ Crawling	☐	☐	☐
☒ Reaching/working overhead	☒	☐	☐
☒ Climbing:	☐	☐	☐
☒ Stairs	☒	☐	☐
Number of stairs: 1 flight (elevator available)			
☐ Ladders	☐	☐	☐
Height of Ladder: _____			
☐ Pushing	☐	☐	☐
☐ Pulling	☐	☐	☐
☒ Lifting/carrying	☒	☐	☐

Describe Activity	Weight
_____	_____ lbs.
_____	_____ lbs.
Proposals, presentations briefcase	15-20 lbs.

8

858

...e job be performed by alternating sitting and standing?
...es ☐ No

...the job require using the feet to operate foot controls?
...es ☒ No If yes, on what type of equipment? Except for driving auto

...portant is good vision in the job?
...cessary for reading or drafting technical documents

...are the major tasks requiring use of one or both hands?	One Hand	Both Hands
...les and marketing travel	☐	☒
...ting and reviewing proposals, technical documents and reports	☐	☒
...king technical and sales presentations	☐	☒
...ing computer for communications/analysis	☐	☒

...formation about the job as it relates to the disability

...the job be modified to accommodate the disability either temporarily or permanently?
Yes ☒ No If yes, explain

...les, marketing, presentations and image building are essential to this position

...possible to offer the employee assistance in doing the job (through use of technology or personal assistance for example)?
Yes ☒ No If yes, explain
...sistance would be substantial and costly thus significantly eroding effectiveness

...tachments and Signature (Attach a copy of the employee's job description)
...No job description available. Resume attached.
...e of person completing this form
Dexana MacQuarrie

Dexana MacQuarrie
Signature

Vice President Administration
Title

4/6/94
Date

Telephone (619) 259-5045 Fax (619) 259-5046

86a

EXHIBIT 2

[Logo] *UNUM*

UNUM Life Insurance Company of America
Western Regional Benefits
101 North Brand Blvd., Suite 800
Glendale, CA 91203-2622
818-247-4151
800-424-2008
FAX 818-956-2640

April 13, 1994

JOHN E WARD
140 WALNUT AVENUE #3B
SAN DIEGO CA 92103

RE: John E Ward DOB: 04-24-1930
Claim Number: 4V32664433
Policy Number: 310727—001

Dear Mr. Ward:

We have completed our review of your application for benefits under the above policy.

We regret that we are unable to continue processing your application for benefits because it was not submitted within the time frame specified in the contract. Under the policy provisions regarding notice and proof of claim, the policy specifies the time period in which this proof must be submitted.

Based on a disability date of May 5, 1992, your elimination period would have been satisfied August 7, 1992. Your application for benefits was received on April 11, 1994. As this is beyond the time frame indicated in the policy, we regret to advise you that we will not be able to give consideration to your application for benefits and are closing your claim file.

If you have new, additional information to support your request for disability benefits, please send it to me at the above address.

If you do not agree with our decision, you may have it reviewed. Should you desire a review, you must send a written request, within 60 days of your receipt of this notice, to:

UNUM
LTD Quality Review Section
2211 Congress Street
Portland, ME 04122-0360

Please be sure to include your Social Security and policy numbers. Your written request should include your comments and views of the issues, as well as any documentation you wish UNUM to consider. You may also request copies of pertinent documents contained in your file. If UNUM does not receive the written request within 60 days of your receipt of this notice, our claims decision will be final.

You may also contact the California Insurance Department if you wish to have them review your claim. If you wish to contact the Department by telephone, you should ask for the Consumer Communications Bureau at 1-800-927-HELP (1-800-927-4357) or 213-897-8921. If you wish to write to the Insurance Department, your letter should be addressed to:

California Department of Insurance
Claims Service Bureau, 11th Floor
300 South Spring Street
Los Angeles, California 90013

If you have any questions, please contact me at 1-800-424-2008 ext. 662.

Sincerely,

/s/ Shawna Shapero
SHAWNA SHAPERO
Disability Benefit Specialist

SS / ts

cc: Maria Bonney

EXHIBIT 3

SHAFFMAN, ILER, PALKOWITZ & DOFT
Attorneys at Law
110 West "C" Street, Suite 1905
San Diego, California 92101

Area Code 619
Telephone 231-1841
Fax (619) 236-7932

June 6, 1994

CERTIFIED MAIL—
RETURN RECEIPT REQUESTED

UNUM LTD QUALITY REVIEW SECTION
2211 Conger Street
Portland, ME 04122-0306

Re: Our Client : John E. Ward
Your Insured : John E. Ward
DOB : 04/24/30
Claim No. : 4V32664433
Policy No. : 310727-001

WRITTEN REQUEST FOR REVIEW

TO WHOM IT MAY CONCERN:

I have been retained by Mr. Ward to represent him as the result of your denial of long term disability benefits which was made on April 13, 1994. Please be advised that this letter is intended to be a request for review as defined in Management Analysis Company's Long Term Disability Income Benefits Booklet, page 28.

On May 5, 1992, John E. Ward became totally disabled as the result of diabetic neuropathy affecting both lower

extremities. At the time of his disability, Mr. Ward was the Chief Executive Officer of Management Analysis Corporation (MAC) and had been employed there for nine years. MAC's in-house benefits administrator was aware of Mr. Ward's disability and in fact was helping coordinate his entitlement to ongoing health care benefits during the summer of 1992. Dexana G. MacQuarrie, Vice President in charge of employee benefits, became aware that Mr. Ward's condition was considered permanent on March 30, 1993. (See attached letter dated March 30, 1993 marked as Exhibit 1). Mr. Ward did not become aware that it was necessary to file an application for long term disability benefits until earlier this year. An application was filed on April 11, 1994 and denied by Shawna Shapiro, Disability Benefits Specialist of the Western Regional Benefits Office on April 13, 1994. (See attached Exhibit 2).

ARGUMENT

Mr. Ward contends that actual notice of his disability was provided to the in-house administrator and as a matter of law that notice was imputed to the insurer, UNUM. In *Elfstrom v. New York Life Ins. Co.* (1967) 67 Cal.2d 503 the California Supreme Court considered the issue of whether an employer which is the named insured under a group insurance policy for the benefit of the employees acts as the agent of the employees or the agent of the insurer in performing the functions necessary to administer the insurance provided by the policy. (See attached Exhibit 3). The high court concluded, in a unanimous decision, that under these circumstances, the employer is the agent of the insurer.

The *Elfstrom* court reasoned that in performing administrative duties related to the group insurance benefits, the employer does not act entirely for its own benefit for the benefit of the employees. Rather, both the insurer and the employer enjoy significant benefits as a result of this arrangement. The employer generally obtains reduced pre-

miums as a result of taking on administrative duties, particularly where there is a large number of employees. (*Elfstrom,* p. 511.) Likewise, the insurer realizes a larger volume of sales and markedly reduced costs for administration. (*Id.*, 513.)

The *Elfstrom* court noted that the insurer in that case had provided written instructions to the employer directing it to perform certain administrative functions such as determining employee's eligibility for insurance, providing pertinent information regarding the employees' salary, class of coverage, etc., and completing the certificate of insurance indicating the amount of coverage. As discussed more specifically below, these facts are very similar to those in the instant case.

In holding that the administrator is the agent of the insurer, the *Elfstrom* court found particularly persuasive the fact that the employee generally has no knowledge or control over the employer's actions in handling the policy or its administration. "An agency relationship is based upon consent by one person that another shall act in his behalf and be subject to his control." (*Id.*, p. 513.) Because the insurer directs the performance of the employer's administrative acts, if these duties are not undertaken properly, the insurer is in a position to exercise more constricted control over the employer's conduct. (*Id.*, pp. 513-514.)

Here, as in *Elfstrom*, the insurer, UNUM, required the employer to perform certain administrative tasks. Section VI, subsection D of the Long Term Disability Contract provides as follows:

1. The employer will furnish at regular intervals to the Company:

   a. information relative to employees:

      i. who qualify to become insured;

      ii. whose amounts of insurance change; and/or

      iii. whose insurance terminates.

   b. *Any other information about this policy that may be reasonably required.*

   The employer's records which, in the opinion of the Company, have a bearing on the insurance will be opened for inspection by the Company at any reasonable time.

Subsection F goes on to discuss Notice and Proof of Claim procedures and indicates that written notice of claim must be given to the Company within certain time periods. It does not specify whose responsibility it is to give notice (i.e., the employee or the employer/administrator which is on notice of the claim or potential claim.)

Based on the discussion in *Elfstrom*, the facts here support a finding that the employer/administrator was an agent of the insurer for purposes of imputing its knowledge of an employee disability claim to the insurer. Specifically,

> The employer here was, under its contract with UNUM, required to perform administrative functions with respect to the disability plan which were similar to those required of the employer in *Elfstrom*. In addition, the employer was further required to perform other unidentified functions such as providing "any other information about the policy which may be reasonably required."

Because this company had a substantial number of employees, both the company and the insurer undoubtedly benefitted from the relationship with the insurer obtaining additional business and the company obtaining reduced premiums, a factor which the *Elfstrom* court considered in its analysis of the agency relationship which exists between insurer and employer/administrator.

Also pursuant to the policy, the company's records were open to inspection by the insurer for any purpose which the insurer deemed appropriate, lending further support to the conclusion that the company had an obligation to adequately maintain its employee files for the benefit of the insurer.

Because the employees were apparently never provided with the entire disability insurance contract between the insurer and the employer, but rather received only a pamphlet entitled "Your Long Term Disability Income Benefits" the employees undoubtedly had little or no knowledge of or control over the employer's actions in administering the policy, another factor deemed important by the *Elfstrom* court. Moreover, this pamphlet specifically provides at page 26:

> 2. In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan.
>
> 3. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

California Law supports a finding that because of the agency relationship which exists between UNUM and MAC, where the plan administrator has actual knowledge of an employee's permanent disability and the employers actively assisting the employee in obtaining and preserving various insurance benefits, the employer's actual knowledge of the employee's potential disability claim should be imputed to the insurer.

Based upon the foregoing it is respectfully requested that UNUM reconsider its denial of beinefits in this matter and provide the LTD benefits Mr. Ward is entitled to.

Dated: 6/6/94

/s/ Brooks L. Iler
BROOKS L. ILER
Attorney fo John E. Ward

cc: Shawna Shapero
Disability Benefit Specialist
UNUM Life Insurance
101 North Brand Blvd., Suite 800
Glendale, CA 91203-2622

[Logo] *UNUM.*

UNUM Life Insurance Company of America
2211 Congress Street
Portland, Maine 04122
207-770-2211
800-822-9103
FAX 207-770-6997

July 12, 1994

BROOKS L ILER
110 WEST C STREET, SUITE 1905
SAN DIEGO CA 92101

RE: John E Ward DOB: 04-24-1930
Claim Number: 4V32664433
Policy Number: 310727—001

Dear Mr. Iler:

We have completed our review of Mr. Ward's Long Term Disability claim and conclude that the decision to deny liability due to late filing was correct.

The contract clearly states that "proof of claim must be given to the Company", and specifies the time frame in which this proof must be given. The "Company" being UNUM Life Insurance Company of America. It appears that Mr. Ward's policy constitutes an ERISA plan. Management Analysis Company, Mr. Ward's employer, through the purchase of group insurance to provide disability benefits to its employees, has established an employee welfare benefit plan within the meaning of ERISA. The U.S. Supreme Court in the *Pilot Life* decision established that questions of contract interpretation arising under an ERISA-regulated plan are issues of federal, not state law. Thus, the question of whether your client's employer was UNUM's "agent" for purposes of this matter is a federal law question, not a California state law question. Under

ERISA, the employer has the sole responsibility to provide employees with timely and accurate disclosure of the terms of the plan to its employees. The fact that he may not have been aware of the existence of the policy or of its provisions does not alter the validity of those provisions.

The Agency Provision of the policy, states:

> For all purposes of this policy, the policyholder acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company without a written authorization.

The Notice and Proof of Claim provision, states:

Proof

a. Proof of claim must be given to the Company. This must be done no later that 90 days after the end of the elimination period.

b. If it is not possible to give proof within these time limits, it must be given as soon as reasonably possible. But proof of claim may not be given later than one year after the time proof is otherwise required.

Under the express terms of the policy, Mr. Ward needed to submit proof of claim by November 5, 1992, and if, and only if, it was impossible for him to do so by that date, no later than November 5, 1993. His claim was not received until April 11, 1994, beyond the time frame stipulated in the policy. Due to Mr. Ward's delayed application for benefits, we are unable to give consideration to his claim.

We regret that our determination could not be more favorable, but we must abide by the policy provisions.

Sincerely,

/s/ Marie Lamson
MARIE LAMSON
Senior Benefit Analyst

ML / ml

cc: Maria Bonney
Michael Stevens

STATUTORY PROVISIONS

ERISA § 2(a), (b), 29 U.S.C. §§ 1001(a), (b):

(a) Benefit plans as affecting interstate commerce and the Federal taxing power

The Congress finds that the growth in size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; that the operational scope and economic impact of such plans is increasingly interstate; that the continued well-being and security of millions of employees and their dependents are directly affected by these plans; that they are affected with a national public interest; that they have become an important factor affecting the stability of employment and the successful development of industrial relations; that they have become an important factor in commerce because of the interstate character of their activities, and of the activities of their participants, and the employers, employee organizations, and other entities by which they are established or maintained; that a large volume of the activities of such plans is carried on by means of the mails and instrumentalities of interstate commerce; that owing to the lack of employee information and adequate safeguards concerning their operation, it is desirable in the interests of employees and their beneficiaries, and to provide for the general welfare and the free flow of commerce, that disclosure be made and safeguards be provided with respect to the establishment, operation, and administration of such plans; that they substantially affect the revenues of the United States because they are afforded preferential Federal tax treatment; that despite the enormous growth in such plans many employees with long years of employment are losing anticipated retirement benefits owing to the lack of vesting provisions in such plans; that owing to the inadequacy of current minimum standards, the soundness and stabiilty of plans with respect to adequate funds to pay promised benefits may be endangered; that owing to the termination of plans before requisite funds have been accumulated,

employees and their beneficiaries have been deprived of anticipated benefits; and that it is therefore desirable in the interests of employees and their beneficiaries, for the protection of the revenue of the United States, and to provide for the free flow of commerce, that minimum standards be provided assuring the equitable character of such plans and their financial soundness.

(b) Protection of interstate commerce and beneficiaries by requiring disclosure and reporting, setting standards of conduct, etc., for fiduciaries

It is hereby declared to be the policy of this chapter to protect interstate commerce and the interests of participants in employee benefit plans and their beneficiaries of financial and other information with respect thereto, by establishing standards of conduct, responsibility, and obligation for fiduciaries of employee benefit plans, and by providing for appropriate remedies, sanctions, and ready access to the Federal courts.

ERISA § 3(1), (16), 29 U.S.C. § 1002(1), (16):

For purposes of this subchapter:

(1) The terms "employee welfare benefit plan" and "welfare plan" mean any plan, fund, or program which was heretofore or is hereafter established or maintained by an employer or by an employee organization, or by both, to the extent that such plan, fund, or program was established or is maintained for the purpose of providing for its participants or their beneficiaries, through the purchase of insurance or otherwise, (A) medical, surgical, or hospital care or benefits, or benefits in the event of sickness, accident, disability, death or unemployment, or vacation benefits, apprenticeship or other training programs, or day care centers, scholarship funds, or prepaid legal services, or (B) any benefit described in section 186(c) of this title (other than pensions on retirement or death, and insurance to provide such pensions).

(16)(A) The term "administrator" means—

(i) the person specifically so designated by the terms of the instrument under which the plan is operated;

(ii) if an administrator is not so designated, the plan sponsor; or

(iii) in the case of a plan for which an administrator is not designated and a plan sponsor cannot be identified, such other person as the Secretary may by regulation prescribe.

(B) The term "plan sponsor" means (i) the employer in the case of an employee benefit plan established or maintained by a single employer, (ii) the employee organization in the case of a plan established or maintained by an employee organization, or (iii) in the case of a plan established or maintained by two or more employers or jointly by one or more employers and one or more employee organizations, the association, committee, joint board of trustees, or other similar group of representatives of the parties who establish or maintain the plan.

ERISA § 402(a), 29 U.S.C. § 1002(a), (b):

(a) Named fiduciaries

(1) Every employee benefit plan shall be established and maintained pursuant to a written instrument. Such instrument shall provide for one or more named fiduciaries who jointly or severally shall have authority to control and manage the operation and administration of the plan.

(2) For purposes of this subchapter, the term "named fiduciary" means a fiduciary who is named in the plan instrument, or who, pursuant to a procedure specified in the plan, is identified as a fiduciary (A) by a person who is an employer or employee organization with respect to the plan or (B) by such an employer and such an employee organization acting jointly.

(b) Requisite features of plan

Every employee benefit plan shall—

(1) provide a procedure for establishing and carrying out a funding policy and method consistent with the objectives of the plan and the requirements of this subchapter,

(2) describe any procedure under the plan for the allocation of responsibilities for the operation and administration of the plan (including any procedure described in section 1105(c)(1) of this title),

(3) provide a procedure for amending such plan, and for identifying the persons who have authority to amend the plan, and

(4) specify the basis on which payments are made to and from the plan.

ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D):

(a) Prudent man standard of care

(1) Subject to sections 1103(c) and (d), 1342, and 1344 of this title, a fiduciary shall discharge his duties with respect to a plan solely in the interest of the participants and beneficiaries and—

(A) for the exclusive purpose of:

(i) providing benefits to participants and their beneficiaries; and

(ii) defraying reasonable expenses of administering the plan;

(B) with the care, skill, prudence, and diligence under the circumstances then prevailing that a prudent man acting in a like capacity and familiar with such matters would use in the conduct of an enterprise of a like character and with like aims;

(C) by diversifying the investments of the plan so as to minimize the risk of large looses, unless under the circumstances it is clearly prudent not to do so; and

(D) in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter or subchapter III of this chapter.

ERISA § 502(a)(1)(1)(B), 29 U.S.C. § 1132(a)(1)(B):

(a) Persons empowered to bring a civil action

A civil action may be brought—

(1) by a participant or beneficiary—

(A) for the relief provided for in subsection (c) of this section, or

(B) to recover benefits due to him under the terms of his plan, to enforce his rights under the terms of the plan, or to clarify his rights to future benefits under the terms of the plan;

ERISA § 503, 29 U.S.C. § 1133:

In accordance with regulations of the Secretary, every employee benefit plan shall—

(1) provide adequate notice in writing to any participant or beneficiary whose claim for benefits under the plan has been denied, setting forth the specific reasons for such denial, written in a manner calculated to be understood by the participant, and

(2) afford a reasonable opportunity to any participant whose claim for benefits has been denied for a full and fair review by the appropriate named fiduciary of the decision denying the claim.

ERISA § 514(a), (b)(2)(A), (B), (d), 29 U.S.C. § 1144(a), (b)(2)(A), (B), (d):

(a) Supersedure; effective date

Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title and not exempt under section 1003(b) of this title. This section shall take effect on January 1, 1975.

(b) Construction and application

(1) This section shall not apply with respect to any cause of action which arose, or any act or omission which occurred, before January 1, 1975.

(2)(A) Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

(B) Neither an employee benefit plan described in section 1003(a) of this title, which is not exempt under section 1003(b) of this title (other than a plan established primarily for the purpose of providing death benefits), nor any trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, on investment company or to be engaged in the business of insurance or banking for purposes of any law of any State purporting to regulate insurance companies, insurance contracts, banks, trust companies, or investment companies.

(4) Subsection (a) of this section shall not apply to any generally applicable criminal law of a State.

(d) Alteration, amendment, modification, invalidation, impairment, or supersedure of any law of United States prohibited

Nothing in this subchapter shall be construed to alter, amend, modify, invalidate, impair, or supersede any law of the United States (except as provided in sections 1031 and 1137(b) of this title) or any rule or regulation issued under any such law.

29 C.F.R. § 2560.503-1(b),(c),(d):

(a) *Scope and purpose.* (1) This section sets out certain minimum requirements for employee benefit plan procedures pertaining to claims by participants and beneficiaries (claimants) for plan benefits, consideration of such claims, and review of claim denials, hereinafter referred to in the aggegate as "claims procedures." Except as otherwise noted, these requirements apply to every employee benefit plan described in section 4(a) and not exempted under section 4(b) of the Employee Retirement Income Security Act of 1974 (the Act).

(b) *Obligation to establish a reasonable claims procedure.* Every employee benefit plan shall establish and maintain reasonable claims procedures.

(1) A claims procedure will be deemed to be reasonable only if it:

(i) Complies with the provisions of paragraphs (d) through (h) of this section, except to the extent that it is deemed to comply with some or all of such provisions under the authority of paragraph (b)(2) or paragraph (j) of this section.

(ii) Is described in the summary plan description, as required by § 2520.102-3,

(iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims, and

(iv) Provides for informing participants in writing, in a timely fashion, of the time limits set forth in paragraphs (e)(3) and (g)(3) and paragraph (h) of this section.

(2) In the case of a plan established and maintained pursuant to a collective bargaining agreement (other than a plan subject to the provisions of section 302(c)(5) of the Labor Management Relations Act, 1947 concerning joint representation on the board of trustees):

(i) Such plan will be deemed to comply with the provisions of paragraphs (d) through (h) of this section if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference.

(A) Provisions concerning the filing of benefit claims and the initial disposition of benefit claims, and

(B) Agrievance and arbitration procedure to which denied claims are subject.

(ii) Such plan wll be deemed to comply with the provisions of paragraphs (g) and (h) of this section (but will not be deemed to comply with paragraphs (d) through (f)) if the collective bargaining agreement pursuant to which the plan is established or maintained sets forth or incorporates by specific reference a grievance and arbitration procedure to which denied claims are subject (but not provisions concerning the final and initial disposition of benefit claims).

(c) *Claims procedure for an insured welfare or pension plan.* (1) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for filing of a claim for benefits with and notice of decision by such company, service or organization.

(2) See paragraph (g) regarding review and final decision on denied claims by insurance companies, insurance services and similar organizations.

(d) *Filing of a claim for benefits.* For purposes of this section, a claim is a request for a plan benefit by a participant or beneficiary. A claim is filed when the requirements of a reasonable claim filing procedure of a plan have been met. If a reasonable procedure for filing claims has not been established by the plan, a claim shall be deemed filed when a written or oral communication is made by the claimant or the claimant's authorized representative which is reasonably calculated to bring the claim to the attention of:

(1) In the case of a single employer plan, either the organizational unit which has customarily handled employee benefits matters of the employer, or any officer of the employer.

(2) In the case of a plan to which more than one unaffiliated employer contributes, or which is established or maintained by an employee organization, either the joint board, association, committee or other similar group (or any member of any such group) administering the plan, or the person or organizational unit to which claims for benefits under the plan customarily have been referred.

(3) In the case of a plan the benefits of which are provided or administered by an insurance company, insurance service, or other similar organization, which is subject to regulation under the insurance laws of one or more States, the person or organizational unit which handles claims for benefits under the plan or any officer of the insurance company, insurance service, or similar organization.

(g) *Review procedure.* (1) Every plan shall establish and maintain a procedure by which a claimant or his duly authorized representative has a reasonable opportunity to appeal a denied claim to an appropriate named fiduciary

or to a person designated by such fiduciary, and under which a full and fair review of the claim and its denial may be obtained. Every such procedure shall include but not be limited to provisions that a claimant or his duly authorized representative may:

(i) Request a review upon written application to the plan;

(ii) Review pertinent documents; and

(iii) Submit issues and comments in writing.

(2) To the extent that benefits under an employee benefit plan are provided or administered by an insurance company, insurance service, or other similar organization which is subject to regulation under the insurance laws of one or more States, the claims procedure pertaining to such benefits may provide for review of and decision upon denied claims by such company, service or organization. In such case, that company, service, or organization shall be the "appropriate named fiduciary".

Supreme Court, U.S.
FILED
JUL 20 1998
OFFICE OF THE CLERK

No. 97-1868

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

ON PETITION FOR A WRIT OF CERTIORARI TO THE
UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF IN OPPOSITION OF RESPONDENT JOHN E. WARD

BROOKS ILER
11770 BERNARDO PLAZA CT.,
SUITE 205
SAN DIEGO, CA 92128
(619) 592-6212

JEFFREY ISAAC EHRLICH
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STATEMENT OF THE CASE

1. Respondent John E. Ward is the former President and CEO of Management Analysis Company ("MAC"). (2a) MAC maintained under ERISA a long term disability plan for its employees, which it purchased from petitioner UNUM Life Ins. Co. Of America. *(Id.)* Ward resigned from MAC in May 1992. *(Id.)* At the time he resigned he was already suffering from diabetic neuropathy that caused him to experience severe and disabling leg pain. (3a)

2. The nature and extent of Ward's illness and resulting disability were diagnosed by December 1992, and in early 1993 Ward had applied for and received state disability benefits. (3a) Ward then contacted MAC's Human Resources department to arrange for a continuation of his insurance coverage under COBRA. (28a) MAC forwarded materials to Ward and explained that in order to extend his benefits it was necessary for him to obtain a disability determination from the Social Security Administration. *(Id.)* Ward obtained a Social Security award of disability and forwarded a copy to MAC. (*Id.*) No one from MAC ever informed Ward that he might obtain disability coverage under MAC's plan. (*Id.*)

3. Ward discovered a pamphlet discussing MAC's plan in April 1994, while cleaning out a safe-deposit box. (*Id.*) He then contacted MAC, who told him he was eligible and sent him an application for benefits. (29a) Ward completed the application and sent it to MAC, who forwarded it to petitioner on April 11, 1994. (*Id.*) Petitioner denied the claim as untimely two days later. (*Id.*) To have been timely UNUM would have had to have received the claim no later than November 5, 1993. (5a) Ward sought

reconsideration under ERISA and UNUM confirmed its decision to deny his claim. (*Id.*)

4. Ward filed suit in federal court under ERISA. (*Id.*) Petitioner moved for and obtained summary judgment against Ward on the ground that his claim was untimely under the plan. (4a)

5. Ward appealed and the Court of Appeals reversed, holding that its decision in *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939 (9th Cir. 1998)(petition for cert. filed in no. 97-1367) required reversal and a remand for application of the California notice-prejudice rule. (5a, 6a) The court instructed the district court to remand the case to the plan administrator to determine whether the plan had suffered prejudice because Ward's claim was late. (6a)

6. After determining to remand the judgment against Ward, the court undertook an alternative analysis of the case, based on Ward's argument that MAC was UNUM's agent, and therefore MAC's actual notice of his claim by March 1993 should operate as notice to UNUM. (7a) Ward's argument was based on *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503, 432 P.2d 731, 63 Cal. Rptr. 35 (1967), which held that an employer administering a group insurance policy was acting as the insurer's agent. (7a, 8a)

7. The court reviewed California decisions after *Elfstrom*, and similar decisions from other jurisdictions, and determined that the proper formulation of the "*Elfstrom* rule" was articulated by the Oregon Supreme Court in *Paulson v. Western Life Ins. Co.*, 636 P.2d 935 (Or. 1981) (12a, 13a n.6) Per *Paulson*, if the insurer exclusively administered the policy the employer is not its agent as a matter of law; if the employer exclusively administered the policy it is the insurer's agent as a matter of law; and if the function of

policy administration is divided agency becomes a question of fact. 636 P.2d at 939. (13a)

8. Petitioner argued that MAC was not its agent as a matter of law because its policy contains a term to that effect (14a) Petitioner claimed that the court was obligated to apply this language no matter what its actual relationship with MAC might have been because ERISA requires courts to adhere to an "absolute and literal" interpretation of the plan documents. (13a) The court disagreed, noting that the law in the Ninth Circuit, and in other circuits was to interpret plans "reasonably," not "literally." (13a n.7) The court found instead that the existence of an agency relationship was a question of fact, and was not controlled by how the policy characterized it. (14a, 15a)

9. Finding no precedent within the Ninth Circuit that addressed the relationship between ERISA and state-law agency principles, the court looked to other circuits, finding persuasive the Fifth Circuit's decision in *Turrill v. Life Ins. Co. Of North America*, 753 F.2d 1322 (5th Cir. 1985). *Turill* reversed a summary judgment against the beneficiary of an ERISA disability plan granted on the ground that his claim was untimely. The *Turrill* court found that an employer's administration of the plan under ERISA could raise an issue of agency under state law, so that notice of the claim to the employer constituted notice to the plan. 753 F.2d at 1324. (17a, 18a)

10. The court below determined that MAC's duties as plan administrator included determining whether employees were eligible for coverage, enrolling them in the plan, issuing certificates of insurance, advising employees on the scope of benefits available, collecting and forwarding premiums to the insurer, and, on at least one occasion helping an employee file a claim for benefits. (19a) In addition, the

court noted that plan documents advised beneficiaries to contact MAC if they had any questions about the plan. (19a) Based on these facts, the court determined that under *Turrill* and *Elfstrom* there was a question of fact under California law regarding the existence of an agency relationship between MAC and UNUM. (20a)

11. The court next considered whether ERISA pre-empted the *Elfstrom* rule in light of this Court's recent decisions in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), and *Cal. Div. Of Labor Enforcement v. Dillingham Construction Co.*, 117 S.Ct. 832 (1997). (20a) The court determined that ERISA did not pre-empt the *Elfstrom* rule, because it did not dictate the benefits to be provided, the manner in which the plan will be administered, or create an agency relationship that did not already exist as a consequence of the parties' course of dealing. (22a-24a) The court found that plan participants and beneficiaries should be permitted to rely on MAC's appearance as UNUM's agent in administering the plan, absent some communication from UNUM to plan members that UNUM had disavowed "the sufficiency of the employer's performance of its functions under the plan." (23a)

12. The court held that whether MAC acted as UNUM's agent could not be determined on the record before it as a matter of law. (24a, 25a) The court explained that the issue became material only in the event that the issue of the timeliness of Ward's notice under the notice-prejudice rule was resolved adversely to him. (25a) In that event, the court instructed the district court to determine whether MAC functioned as UNUM's agent in administering the plan, "and if so, whether Ward furnished timely notice and proof of his

disability to MAC, and if so, to what remedies Ward may be entitled." (25a)

REASONS FOR DENYING THE WRIT

I. The Reasons For Denying Review Based On the Application of California's Notice-Prejudice Rule Are Stated In The Brief In Opposition to the Petition Filed In *Cisneros v. UNUM*

The Court of Appeals decided this case based on its decision in *Cisneros v. UNUM*. (6a) UNUM's petition in that case is currently pending.[1] To the extent that UNUM seeks review of the decision below because it applies the notice-prejudice rule (Pet. at 9-16), the reasons for denying the writ are stated in Cisneros's brief in opposition to UNUM's petition at pages 5 through 13. Ward's remaining arguments for why the petition should be denied pertain to the second question presented in the petition.

II. The Petition Seeks Review of a Contingent Alternative Holding in an Interlocutory Case, Which Is Unlikely to Have Any Role in The Ultimate Disposition of The Case

The Court of Appeals did not discuss the potential application of the *Elfstrom* rule until after it held that the judgment would be reversed and remanded for application of the notice-prejudice rule under *Cisneros*. (6a) The court did not apply the *Elfstrom* rule; it remanded the case to the district court with instructions to remand to the plan

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[1] No. 97-1867, filed May 20, 1998.

administrator to apply the notice-prejudice rule. (25a) The district court was to consider whether the *Elfstrom* rule applies to the case *only if* the plan administrator determines that petitioner had suffered actual prejudice as a result of Ward's late claim. (25a)

While this Court has jurisdiction to review an interlocutory decision of the Court of Appeals under 28 U.S.C. § 1254(1), it is Ward's understanding that it is ordinarily not the Court's practice to do so unless "there is an important and clear-cut issue of law that is fundamental to the further conduct of the case." *Randolf Central School District v. Aldrich*, 506 U.S. 965 (1992)(White, J., dissenting from denial of certiorari) [citations omitted]. This is not such a case.

Petitioner's strong opposition to the application of the notice-prejudice rule is presumably premised on the difficulty it imposes on insurers to show that they suffered any actual prejudice because the claim was filed late. In this case petitioner attempted to persuade the Court of Appeals that it had been prejudiced, but the court noted that petitioner had offered little, if any, evidence to support its claim. (7a n.4) While the issue remains open for further consideration below, the court plainly felt that it was unlikely that petitioner would be able to prove that an investigation that could have been undertaken in November 1993 (the plan deadline for Ward's claim) was not possible by April 1994 (the actual filing date). (*Id.*)

Because the Court of Appeals made application of the *Elfstrom* rule a contingent alternative holding, it cannot be said that its application is fundamental to the further conduct of the case. This case is therefore a poor vehicle for review.

III. The Application of State-Law Agency Principles To ERISA Plans Has Not Been At The Forefront Of ERISA Litigation — Only Two Circuits Have Considered It

Issues of ERISA pre-emption have made their way to this Court's docket 16 times,[2] and have been the subject of thousands of decisions in the lower courts.[3] Yet, despite the frequency with which ERISA pre-emption cases occur, only two circuit court decisions have considered whether, under state-law agency principles, notice to a plan administrator can operate as notice to the plan. Those cases are the case below and the Fifth Circuit's decision in *Turrill*. Nor have the district courts had to address the issue. The court below located only one pertinent decision from a district court.[4] (23a n.13)

In its petition, UNUM argues that the Ninth Circuit's decision conflicts with virtually every other circuit in some way, but never identifies a single decision that deals with the application of agency principles to ERISA plans. Petitioner therefore comes to this Court seeking review of an issue that has only twice reached a circuit court and which was decided

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[2] *California Div. of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 117 U.S. at 842-843 n.1 and n.2 (1997)(Scalia, J., concurring).

[3] *District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 135, and n.3 (Stevens, J., dissenting) (observing that in 1992, a LEXIS search uncovered more than 2,800 opinions on ERISA pre-emption).

[4] *Kennedy v. System One Holdings, Inc.*, 835 F. Supp. 947 (S.D.Tex. 1993), was called to the court's attention by petitioner.

consistently in both cases. There would appear to be no compelling need for this Court to intervene.

IV. The Petition Is Based on a Literal Interpretation of the Words "Relate To" in § 514(a) of ERISA, an Approach This Court Abandoned in 1995; The Decision of the Court Below Is Fully Consistent With this Court's Current ERISA Pre-emption Cases

The petition relies on the outmoded approach to ERISA pre-emption foreclosed by *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. at 645. In *DeBuono v. NYSA-ILA Medical and Clinical Services Fund*, 117 U.S. 1747, 1751 (1997), the Second Circuit relied on the same improper approach to reinstate its original judgment after this Court had vacated its earlier judgment and remanded for further consideration in light of *Travelers*. In reversing, this Court explained that the lower court had erroneously adhered to its previous "expansive and literal interpretation of the words 'relate to' in § 514(a) of ERISA," which "fail[ed] to give proper weight to *Travelers*' rejection of a strictly literal reading of § 514(a)." 117 U.S. at 1751. Not surprisingly, the petition does not cite *DeBuono*.

Here, the petition does cite *Travelers*, but does not discuss or recognize the limitations that case placed on the pre-emptive scope of § 514(a). *Travelers* held that the "relates to" language in § 514(a) was not intended to modify "the starting presumption that Congress does not intend to supplant state law." 514 U.S. at 654. Under *Travelers* and *DeBuono* state laws of general application that operate in areas traditionally subject to local regulation will not be

found to "relate to" an ERISA plan even if they impose some indirect economic cost on the plan or its administration. *Travelers*, 514 U.S. at 668; *DeBuono*, 117 U.S. at 1752. These laws are not pre-empted because their connection to ERISA plans is simply too tenuous, remote or peripheral to the plan. *Shaw v. Delta Air Lines*, 463 U.S. 85, 100, n.21 (1983).

In *DeBuono*, the Court held that New York's tax on hospitals did not relate to an ERISA plan, even though some plans owned hospitals and were taxed directly. The Court explained that the tax did not intrude on ERISA plans in a way Congress had forbidden, stating:

> "This is not a case in which New York has forbidden a method of calculating pension benefits that federal law permits, or required employers to provide certain benefits. Nor is it a case in which the existence of a pension plan is a critical element of a state cause of action, or one in which the state statute contains provisions that expressly refer to ERISA or ERISA plans." 117 S.Ct. at 1752. [footnotes omitted].

These observations are all applicable here. In applying the *Elfstrom* rule the court below merely held that where an employer was, in fact, functioning as the agent for the plan insurer, state-law agency principles would dictate that notice to the agent constituted notice to the principal. This application to an ERISA plan of a state-law principle of general application is fully consistent with this Court's approach to ERISA pre-emption.

The Court's decision in *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), demonstrates that § 514(a) is not a barrier to the application of the *Elfstrom*

rule. *Mackey* held that application of a general state garnishment statute to permit garnishment of plan participants' benefits did not "relate to" the plan, even though application of the statute imposed direct administrative costs and burdens on the plan. 486 U.S. at 831.

The Court's conclusion rested on two premises. First, ERISA expressly permits a plan to "sue and be sued" as an entity, and it is commonplace for plans to be sued for "run-of-the-mill state-law claims" by creditors or even tort victims. *Id.* at 833. Second, since ERISA does not contain an enforcement mechanism for judgments against a plan, state-law methods of collecting money judgments must apply to ERISA plans. *Id.* at 833-834. The Court concluded that ERISA therefore does not pre-empt state-law methods for enforcing judgments against ERISA plans, including garnishment. *Id.* at 834.

The significance of the Court's analysis in *Mackey* for this case is its rejection of the argument that § 514(a) should be construed to permit the use of state-law methods to enforce judgments against ERISA plans, *except* when the mechanism affects whether benefits will be paid to a plan participant. 486 U.S. at 835. The Court held that this interpretation of § 514(a) was untenable because a garnishment law that did not "relate to" an ERISA plan when invoked by a plan creditor could not "relate to" the plan when invoked by a plan beneficiary. *Id.* at 836.

The Ninth Circuit's decision below is fully consistent with this analysis. Even petitioner does not suggest here that the state-law agency principles applied in *Elfstrom* would not apply in the type of "run-of-the-mill" state-law lawsuits described in *Mackey*. If those principles are available to plan creditors or tort victims, *Mackey* teaches that they do not become pre-empted when invoked by plan beneficiaries.

Petitioner makes much of the fact that the plan states that the employer is not its agent, and the *Elfstrom* rule, if applied, would be inconsistent with this statement. (*See, e.g.*, Pet. at 11-14). This is a variant of petitioner's argument below that ERISA required courts to follow an "absolute and literal" interpretation of all plan language. (13a-14a) The court properly rejected this claim, noting that courts were required to interpret a plan "reasonably," not "literally." (14a n.7)[5]

The court below found that petitioner's conduct was sufficient to raise as a question of fact (should it become necessary to determine whether to apply the *Elfstrom* rule) whether petitioner had relied on the employer to function as its agent. (20a) If the *Elfstrom* rule is ever applied, it would merely "describe in legal terms a relationship that already existed in fact." (22a)

ERISA itself recognizes that the test for whether a person is a "fiduciary" under the statute rests on the actual duties the person performs, and not their title. § 3(21)(A)(i), 29 U.S.C. § 1102(21)(A)(i). *See, e.g., Lockheed Corp. v. Spink*, 517 U.S. 882, 890 (1996) (person becomes fiduciary under ERISA by fulfilling certain defined functions). Nothing in ERISA or the decisions of this Court suggests that where a party's conduct actually conflicts with some provision in the plan purporting to describe the party's role, a court must choose form over substance. *Leigh v. Engle*, 727 F.2d 113, 141 n.33 (7th Cir. 1984)("we think ERISA directs

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[5] For this point the court relied upon *Saffle v. Sierra Pacific Power Co. Long Term Disability Income Plan*, 85 F.3d 455, 458 (9th Cir. 1996)(plan defining disability as inability to perform "each and every" job duty could not be construed literally); *Helms v. Monsanto Co., Inc.*, 728 F.2d 1416 (11th Cir.1984)(same); and *Torix v. Ball Corp.*, 862 F.2d 1428 (10th Cir.1988) (same).

courts to look beyond Engle and Libco's formal authority . . . and to consider what real authority they had . . . ."); *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 61 (4th Cir. 1992)(court looks beyond plan formalities to determine if defendant, in fact, exercised the authority of a fiduciary).[6]

The decision below therefore does not conflict with the cases cited by petitioner that recognize that a court may not re-write an ERISA plan. (Pet. at 14) None of the cases petitioner cites involve an inconsistency between the actual relationship between the plan insurer and the plan administrator, and the description of that relationship in the plan.[7]

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[6] In a related context, several circuits have held or suggested that the party performing the duties of a plan administrator may be held liable for failing to administer the plan in accordance with ERISA's dictates, even if the plan designates another party as the plan administrator. *See, e.g., Law v. Ernst & Young*, 956 F.2d 364, 373 (1st Cir. 1992)(holding de facto administrator can be held liable); *Rosen v. TRW, Inc.*, 979 F.2d 191, 193-194 (11th Cir. 1992)(same), *Fischer v. Metropolitan Life Ins. Co.*, 895 F.2d 1073, 1077 (5th Cir. 1990)(noting that argument has "intuitive appeal," but finding no need to reach it because there was no violation of ERISA), *Jones v. UOP*, 16 F.3d 141, 144 (7th Cir. 1994)(court "could imagine" case in which plan sponsor could be estopped to deny that it was the administrator, but this is not that case), but *see, McKinsey v. Sentry Ins.*, 986 F.2d 401, 404 (10th Cir. 1993)(ERISA does not recognize a de facto administrator, but permitting actions of putative de facto administrator to be imputed to designated administrator); *Crocco v. Xerox Corp.*, 137 F.3d 105, 107 (2d Cir. 1998)(ERISA does not recognize de facto administrator). The instant case does not raise the issue of whether a de facto administrator can exist, or whether it can be held liable for statutory penalties under § 502(c)(1).

[7] Petitioner's lengthy string cite at p. 14 of the petition cites two cases for the self-evident proposition that courts may not re-write ERISA, and eight cases stating that courts must not re-write ERISA plans. Each

V. The Decision Below Does Not Create a Split in The Circuits

To the extent that petitioner claims the decision below creates a split in the circuits its argument is predominantly directed to the application of the notice-prejudice rule, and is addressed in the brief in opposition filed in *Cisneros*. With respect to the potential application of the *Elfstrom* rule, as explained above, petitioner cannot cite any case, other than the Fifth Circuit's decision in *Turrill*, which considers whether agency principles permit notice given to the administrator to be imputed to the plan.

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is inapposite here. *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992), held that plaintiff could not assert a claim under ERISA for oral representations of coverage. In *Hunt v. Hawthorne Assoc. Inc.*, 119 F.3d 888 (11th Cir. 1997), the court held that a retired Eastern Airlines pilot could not circumvent a plan amendment that discontinued lump-sum distributions. *Edwards v. Great-West Life Assurance Co.*, 20 F.3d 748, 750 (7th Cir. 1994), enforced a term in the plan that required an employee to be "actively at work" on the day he first became eligible for benefits. Similarly, *Burnham v. The Guardian Life Insurance Company of America*, 873 F.2d 486, 490 (1st Cir. 1989), held that an employee who was bed-ridden with cancer at the time of his death was not a "full-time employee" as the plan defined that term. In *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d at 56-57, the Fourth Circuit held that a plan beneficiary could not recover benefits where the plan insurer terminated her coverage because her employer had failed to pay premiums. *Boyer v. Douglas Components Corp.*, 986 F.2d 999, 1004 (6th Cir. 1993), held that an employer's verbal assurances that former employees would continue to receive benefits was not enforceable if it conflicted with the terms of the plan. *Cefalu v. B.F. Goodrich Co.*, 871 F.2d 1290, 1296 (5th Cir. 1989), held that oral assurances that a beneficiary's retirement benefits would be the same under one plan option as under another could not be enforced.

Petitioner claims that the decision below conflicts with *Jass v. Prudential Health Care Plans, Inc.*, 88 F.3d 1482 (7th Cir. 1996). There is no conflict. In *Jass*, the gravamen of the plaintiff's claims was that her health plan improperly denied her benefits for post-surgical rehabilitation and as a result her doctor failed to provide her with adequate treatment. 88 F.3d at 1485. She attempted to sue the plan, the plan employee who made the benefits determination, and the doctor. Her claims against the plan included a claim for vicarious liability based on the negligence of the employee and the doctor. *Id.*

After unraveling several jurisdictional knots the *Jass* court concluded that plaintiff's claims were, in essence, a single claim under ERISA for the denial of plan benefits, and remanded to permit her to proceed on that basis. 88 F.3d at 1494.

Here, unlike Ms. Jass, Ward does not seek to hold petitioner liable for damages on a vicarious liability theory based on a wrong committed by its agent. He does not seek to hold petitioner vicariously liable at all; rather, should it become necessary, he only seeks to impute MAC's notice of his claim to UNUM on an agency theory so that he can recover benefits due under the plan.

VI. The Decision Below Does Not Conflict with Pilot Life

Point IV of the petition suggests that the decision below conflicts with ERISA's civil enforcement provisions and therefore attempts to circumvent *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987). (Pet. at 22-25) There is no conflict. *Pilot Life* held that Mississippi's law of bad faith was pre-empted by ERISA for two reasons: (1) it "related to"

an ERISA plan, but was not within the scope of the savings clause, and (2) it created a remedy that was outside of the civil enforcement provision of ERISA, § 502(a). As shown above, the *Elfstrom* rule does not refer to ERISA plans, and its connection with them is too tenuous and remote to fall within ERISA's pre-emptive scope under § 514(a).

Nor would application of the *Elfstrom* rule create a remedy outside of the scope of those contained in § 502(a). In *Pilot Life* the plaintiff asserted a claim for damages based on the plan's failure to process his claim for benefits properly, not a claim for plan benefits. Here, all Ward seeks are plan benefits, a remedy expressly granted by § 502(a)(1)(B). He does not seek an extra-contractual remedy, and therefore does not seek to circumvent *Pilot Life*.

CONCLUSION

The Petition for a Writ of Certiorari should be denied.

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Supreme Court of the United States
OCTOBER TERM, 1997

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,
v.
JOHN E. WARD,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

No. 97-1868

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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REPLY BRIEF FOR PETITIONER

I. INTRODUCTION

Petitioner, UNUM Life Insurance Company of America ("UNUM"), submits this Reply Brief to respond to the Brief in Opposition and discuss the District of Columbia Circuit's recent decision in *O'Connor v. UNUM Life Ins. Co. of America*, No. 97-5244, 1998 U.S. App. LEXIS 15117 (D.C. Cir. July 7, 1998),[1] filed after the petition for a writ of certiorari. The need to grant certiorari has become even more pressing since UNUM filed its petition. As shown by *O'Connor*, still another appel-

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[1] The *O'Connor* decision is reproduced in full in the Appendix. The defendant in that case will request the D.C. Circuit by August 14, 1998 to stay the mandate pending this Court's disposition of the certiorari petitions in *Ward* and in *Cisneros v. UNUM Life Ins. Co. of America*, 135 F.3d 1276 (9th Cir. 1998), petition for cert. filed, 66 U.S.L.W. 3773 (U.S. May 20, 1998) (No. 97-1867).

late court has filed a decision deepening the acknowledged Circuit conflict over the standard for application of ERISA's "saving" clause for state insurance regulation.

II. THE WRIT SHOULD BE GRANTED BASED ON HIGHLY-SIGNIFICANT, IRRECONCILABLE CIRCUIT CONFLICTS.

A. The Circuits Are In Sharp Conflict Over The Standards For Application Of ERISA's Preemption And "Saving" Clauses.

As shown by the petition, one of ERISA's chief purposes is to bar state laws that "*mandate*[] employee benefit structures or their *administration*," "*prohibit*" what is "permitted" by federal law, "preclude *uniform administrative practice*," or provide *"alternate enforcement mechanisms." New York State Conf. of Blue Cross-Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995) (emphasis added). The standards for application of ERISA's preemption and "saving" clauses involve highly significant, recurring issues affecting all ERISA plans across the nation. These issues impact an enormously wide variety of state rules including "notice-prejudice," as reflected by the *Ward, Cisneros* and *O'Connor* decisions, as well as numerous others such as "agency," as reflected by *Ward*, "ambiguity," "unreasonableness," "adhesion contract" "rolling accruals" for statute of limitations, and "bad faith" claims-handling rules. The list has no limits.

In applying the "*Elfstrom*" agency law rule,[2] the Ninth Circuit in *Ward* adopted an extraordinarily narrow standard for ERISA preemption, one that cannot be squared with the plain language of ERISA or Congress' key objectives. If a state law rule dealing with fiduciary conduct, governing plan administration and requiring the payment of plan benefits—the very core of ERISA—does not have a "connection with" an ERISA plan triggering preemption

[2] *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503 (1967).

under ERISA § 514(a), *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), and *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990) (ERISA preempts where "the existence of a . . . plan is a critical factor in establishing liability under state law"), then the preemption clause has absolutely no meaning, a result Congress could not have intended. 29 U.S.C. § 1144(a). At the same time, the District of Columbia and Ninth Circuits have also adopted an extraordinarily broad "saving" clause standard that cannot be squared with ERISA's plain language or Congress' main goals. The courts' simultaneous contraction of the preemption clause to a virtual nil, and their correspondingly large expansion of the "saving" clause, have the net effect of resurrecting state law as the primary vehicle for regulating the fiduciary standards, plan administration and civil enforcement for all ERISA plans. This will produce the crazy quilt of conflicting plan rules across the land that ERISA was enacted to eliminate. ERISA § 514(a); *Pilot Life, supra; Ingersoll-Rand, supra.* Additionally, both the new ERISA preemption and "saving" clause standards will produce results 180 degrees at variance to the standards adopted by the other Circuits which have followed ERISA's statutory scheme. Consequently, the employee benefit laws and rules for plan administration in California, Arizona and the District of Columbia, for example, now differ markedly from those in Texas, Florida, Illinois, Kansas and dozens of other states.

At present, the Ninth and Seventh Circuits have divided over whether ERISA's preemption standard allows state law common-law agency claims to control fiduciary standards, plan administration and benefit payments.[3] More-

[3] *Ward, supra,* and *Jass v. Prudential Health Care Plan*, 88 F.3d 1482, 1488-1490 (7th Cir. 1996) (ERISA preempts state law agency claims related to a denial of benefits). Mr. Ward's attempt to extinguish this conflict by contending that the *Ward* decision involved only whether oral notice to the plan sponsor can be a substitute for the plan's requirement for written notice to the plan

over, decisions in seven Circuits have held that either all three McCarran-Ferguson factors must be satisfied for ERISA's "saving" clause to apply,[4] or at the very least the first factor—the transfer of risk of loss—must be met.[5] Conversely, courts in three Circuits have held that all three factors are not required.[6] The *O'Connor* decision thus increases to ten the Circuits divided over this key "saving" clause issue.

In short, vastly different holdings as to the ERISA pre-emption and "saving" clause standards have now placed the great majority of Circuits in irreconcilable conflicts over issues that are central to the administration of the nation's employee benefit plan system. These are highly-significant conflicts which affect the entire country and can only be resolved by this Court.

B. The *O'Connor* Decision Not Only Deepens The Conflicts, But Also Clashes With ERISA's Statutory Scheme.

In *O'Connor*, the District of Columbia Circuit, extending the acknowledged conflict still farther, held that ERISA "saves" a state common-law rule of general application even though it not only directly impacted plan administration and benefit payment, but also failed to satisfy all three

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fiduciary is transparently incorrect. The ERISA regulations contemplate the filing of *written* claims with the insurance company. 29 C.F.R. § 2560.503-1(c)-(d). Moreover, the Ninth Circuit's holding was not so limited; rather, by citation to *Elfstrom*, it subjects the relationship between the plan sponsor and the fiduciary to *all* aspects of California agency law.

[4] *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.), *cert. denied*, 117 S.Ct. 387 (1996); *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993); *Anschultz v. Connecticut Gen'l Life Ins. Co.*, 850 F.2d 1467, 1468-1469 (11th Cir. 1988).

[5] *See* decisions cited in the petition at page 10, note 6.

[6] *Cisneros, supra; O'Connor, supra; Ward, supra; Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 940 (6th Cir. 1997).

McCarran-Ferguson criteria for the "business of insurance." Indeed, the rule did not even involve the transfer of the risk of loss, which this Court has described as an " 'indispensable characteristic of insurance' " [7] *See also Barnett Bank of Marion County, N.A. v. Nelson*, 517 U.S. 25, 39 (1996) (the spreading of risk lies "at the core of . . . McCarran-Ferguson . . . concerns").

Essentially, *O'Connor*, following in the Ninth Circuit's footsteps, attempted to reduce the standard for application of ERISA's "saving" clause to the simplicity of the rhetorical question posed by *Cisneros*, "If California's rule does not regulate insurance, what does it regulate?" [8] As shown below, ERISA's carefully-crafted statutory framework is simply incompatible with the extraordinary variety of common-law rules of general application preserved by these "saving" clause holdings. The *Ward* pre-emption standard is also wholly foreign and destructive to ERISA's statutory scheme. In conflict with other Circuits, these three decisions pry open the administration of both self-funded and insured ERISA plans—an area intended to be " 'exclusively a federal concern,' " *Pilot Life*, 481 U.S. at 45-46 (citation omitted)—to virtually unlimited state common-law regulation, the exact opposite of ERISA's statutory regimen and Congress' objectives. All of this highlights the need for immediate review by this Court.

The *O'Connor* decision—similar to *Cisneros* and *Ward*—first overlooks the fact that the California "notice-prejudice" rule is nothing more than a basic principle of contract law which applies in *all* contracts, not merely insurance policies. Parties to all contracts have a duty to cooperate, including a duty with respect to notices, *see Restatement (2d) of Contracts*, § 205, and illustration 7

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[7] *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-213 (1979).

[8] *Cisneros*, 134 F.3d at 946.

(insurance policy notice and proof of loss provisions subject to duty to cooperate), with only a *prejudicial* breach relieving the other party of its duty to perform.[9] This contract rule applies not only to insurance contracts, *Campbell v. Allstate Ins. Co.*, 60 Cal.2d 303 (1963) ("notice-prejudice" rule based on "cooperation" clause in insurance contract), but also to *every* contract in California. *Universal Sales Corp. v. California Press Mfg. Co.*, 20 Cal.2d 751 (1942) (the duty to cooperate exists "[i]n every contract.") Unlike the mandated-benefits statute in *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), the California rule involving "notices" admittedly does not transfer the risk of loss; it is not unique to the insurance industry; it only purports to "regulate[] the *administration* of policies, *not* their substantive terms";[10] and it merely shifts the legal risks that would arise when a claim for plan benefits is asserted under the contract.

The California "notice-prejudice" rule, therefore, is no more specific to the insurance industry, nor satisfies the McCarran-Ferguson criteria, that the Mississippi law of "bad faith" addressed in *Pilot Life*, 481 U.S. at 49-50. Even though the Mississippi Supreme Court had "*identified* its law of bad faith with the insurance industry," this Court concluded that the "*roots* of this law" were

[9] *Aetna Cas. and Surety Co. v. Murphy*, 206 Conn. 409, 538 A.2d 219 (1988) (justifying adoption of "notice-prejudice" rule on general contract principle of avoiding a disproportionate forfeiture); *Smith, Valentino & Smith, Inc. v. Superior Court of Los Angeles Cty.*, 17 Cal. 3d 491, 497 (1976) (prior breach may be *de minimis*).

[10] *See Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 570 (11th Cir.) (ERISA preempts statute requiring notice for cancellation of insurance coverage to be effective) (emphasis added), *cert. denied*, 513 U.S. 808 (1994); *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 942 (6th Cir. 1997) (ERISA preempts statute permitting rescission of insurance policy in case of willful misrepresentation by plan participant; "saving" clause not applicable because statute does not spread risk or "affect the substantive terms" of the insurance contract).

"firmly planted in the general principles of Mississippi tort and contract law." *Id.* at 49-50 (emphasis added). Consequently, it held that the state law did not pass the "common sense" test for "regulating insurance." *Id.* Further, it held that the law did not satisfy all of the McCarran-Ferguson criteria because it failed to involve the transfer of risk of loss, was "no more 'integral' to the insurer-insured relationship than any State's general contract law," and was not unique to the insurance industry. *Id.* at 50-51. California's rule involving "notices" is exactly parallel. While often "identified" with insurance cases, the doctrine has its roots in and is merely part of a general principle of contract law applicable to all California contracts. Moreover, had Congress intended to include such rules of general application within the insurance exception, it could have easily so provided as it did in ERISA § 514(b)(4) by excepting "any *generally applicable* criminal law of a State" from ERISA's preemption provision. *See* 29 U.S.C. § 1144(b)(4) (emphasis added).

The *O'Connor* decision also overlooks the fact that even if the California "notice-prejudice" rule could somehow be deemed a law "regulating insurance," it directly impacts plan administration, fiduciary responsibility and suits for the payment of benefits and, accordingly, would be preempted under conflicts preemption analysis for two closely-related reasons. First, the rule directly conflicts with ERISA's substantive provisions governing fiduciary standards, claims-processing and payment, plan administration, and clashes with its exclusive civil enforcement scheme. ERISA §§ 401-404, 502(a)(1)(B)-503, 29 U.S.C. §§ 1101-1114, 1132(a)(1)(B)-1133; 29 C.F.R. § 2560.503-1; *Pilot Life*, 481 U.S. at 50-57; *Ingersoll-Rand*, 498 U.S. at 139. Second, the rule is preempted by the joint application of McCarran-Ferguson and ERISA's "saving" clause for pre-existing federal laws. ERISA does not "alter . . . invalidate . . . or supersede

any law of the United States. . . .," [11] one such pre-existing law being McCarran-Ferguson. *See Metropolitan Life*, 471 U.S. at 744 n.21. Consistent with federal supremacy principles, McCarran-Ferguson provides that federal legislation which "specifically relates" to the business of insurance will displace any conflicting state law. 15 U.S.C. § 1012(b).

If, as the *O'Connor* court held, a state common-law rule which directly impacts claims-processing, plan administration and suits for benefits "regulates the relationship between insurer and insured" (App. at 9a), then *a fortiori* ERISA also "specifically relates" to the business of insurance in this context and therefore preempts state law pursuant to 15 U.S.C. § 1012(b). As shown above, ERISA directly governs fiduciary standards, claims-proccessing and payment and plan administration, while providing an *exclusive* civil enforcement scheme. *See Pilot Life, supra; John Hancock Mut. Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 99-100 (1993) (ERISA preempts state regulation of the "business of insurance" if it presents a "direct conflict" with federal law or "stands as an obstacle to the accomplishment of the full purposes and objectives of Congress" (citation omitted)).

The *O'Connor* decision thus not only deepens the acknowledged Circuit conflict on the standard for application of ERISA's "saving" clause, but also underscores the exact reasons why this Court should swiftly intervene over the welter of conflicting decisions on the preemption and "saving" clause standards. The policy reasons which gave rise to ERISA include the need for interstate employers to have a uniform, federal employee benefits law, and to be able to administer their plans the same way in all 50 states. *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983); *Pilot Life, supra*; ERISA § 2, 29 U.S.C.

[11] ERISA § 514(d), 29 U.S.C. § 1144(d).

§ 1001. These policy grounds are even more pressing in this era of telecommuting and virtual offices, an era which has seen the workplace itself rapidly become *national* in scope. The *Ward, Cisneros* and *O'Connor* decisions both undermine these central goals embodied in ERISA and throw the Circuits into significant conflicts nationwide which only this Court can resolve.

C. The Decision Below Is Not Interlocutory.

Mr. Ward's first premise—without citation of authority—that the "*Efstrom*" agency law holding is a "contingent alternative holding in an interlocutory case" is plainly wrong. The Ninth Circuit's holding that ERISA does not preempt state agency law directly impacting plan administration and benefit payment because the state law somehow fails to have a "connection with" the plan is final and conclusive no matter how wrongly decided. Even a district court's remand of an ERISA matter to the plan administrator is a final and appealable judgment under 28 U.S.C. § 1291, rather than an "interlocutory" order under § 1292. *See Snow v. Standard Insurance Co.*, 87 F.3d 327, 330 (9th Cir. 1996) (taking jurisdiction of a remand order in an ERISA case as a final judgment under § 1291).[12]

Mr. Ward's second argument, that the Ninth Circuit's agency law holding is not certain to be applied, is both irrelevant and incorrect. This startling decision that state agency law not only governs the relationship between a plan fiduciary and the plan sponsor serving as administrator, notwithstanding ERISA's own comprehensive regulation of fiduciary conduct,[13] but also may require the

[12] The treatment of a remand order as a final judgment is consistent with *Sullivan v. Finkelstein*, 496 U.S. 617, 625 (1990) (district court's decision invalidating Social Security regulations and remanding for a benefits determination was "unquestionably" a "judgment").

[13] ERISA §§ 401-414, 503, 29 U.S.C. §§ 1101-1114, 1133.

fiduciary to pay benefits contrary to the plan's written terms, is final and conclusive on the agency law issue. *See Herrington v. County of Sonoma*, 706 F.2d 938, 939 (9th Cir. 1983) (lower court's abstention ruling was a "final decision" because "the impact here was to send [plaintiff] effectively out of court" (citation omitted)). This agency law decision applies immediately to all ERISA plans throughout the Ninth Circuit and, accordingly, it warrants immediate review.

CONCLUSION

In view of the increasingly wide-spread Circuit conflicts over the standards for application of ERISA's preemption and "saving" clauses, the "centrality of pension and welfare plans in the national economy," *Boggs v. Boggs*, 117 S.Ct. 1754, 1760 (1997), and the great significance of these issues, petitioner urges that the writ of certiorari be granted.

Respectfully submitted,

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APPENDIX

APPENDIX

UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

No. 97-5244

MARY O'CONNOR,
Appellant

v.

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Appellee

April 17, 1998, Argued
July 7, 1998, Decided

Appeal from the United States District Court
for the District of Columbia
(No. 96cv02158)

Before: WILLIAMS, GINSBURG, and GARLAND, Circuit Judges. Opinion for the Court filed by Circuit Judge GINSBURG.

OPINION

GINSBURG, Circuit Judge: Mary O'Connor sued her former employer and its insurance company for their failure to pay long-term disability benefits under an employee benefit plan. The district court dismissed the case against the insurance company because O'Connor

failed to submit timely proof of her claim, and transferred the case against the employer (and the receiver thereof) to the Central District of California. For the reasons stated below we reverse.

I. Background

Western Federal Savings and Loan Association provided its employees with a long-term disability benefit plan insured by the UNUM Life Insurance Company of America and governed by the Employee Retirement Income Security Act, 29 U.S.C. § 1001 *et seq.* Under the terms of the plan an injured employee must give UNUM written notice of any claim "within 30 days of the date disability starts, if that is possible" or else "as soon as it is reasonably possible to do so." In addition, the employee must provide proof of the claim "no later than 90 days after the end of the elimination period," which ends 180 days after the onset of the disability, or else "as soon as reasonably possible," but in no event more than "one year after the time proof is otherwise required." Therefore, the latest an employee may file a timely proof of claim is 270 days plus one year after the onset of her disability.

In 1991 O'Connor was an assistant manager in a Northern California branch office of Western Federal, which had its principal place of business in Southern California. In July 1991 O'Connor became disabled, took a leave of absence, and received workers' compensation benefits. Western Federal terminated her employment effective August 7, 1992.

O'Connor contends that despite her asking repeatedly whether she was entitled to additional benefits Western Federal never told her about the long-term disability plan. Nor did O'Connor ever receive a summary plan description, as required by the ERISA.

In early 1993 O'Connor learned from a friend about the long-term disability plan. On March 18 of that year O'Connor submitted a notice of claim to Western Federal and sent the physician statement portion of the proof-of-claim form to her doctor, who forwarded the completed form to Western Federal in May. UNUM received the proof-of-claim form in mid-May, 42 or 43 days late. In July UNUM informed O'Connor of its final decision to deny her claim because she had not filed the proof of claim within the time limit set by the plan.

Meanwhile, in June 1993 the United States had placed Western Federal into receivership, and the Resolution Trust Corporation had been appointed receiver. Subsequently, the Federal Deposit Insurance Corporation succeeded the RTC as receiver.

In September 1995 O'Connor filed suit against UNUM, Western Federal, and the receiver in the United States District Court for the Northern District of California. The FDIC moved to dismiss and in September 1996 the court held that the case was in the wrong venue because a claim against the FDIC as receiver must be filed in either the district in which the depository institution had its principal place of business (in this case the Central District of California), or in the District of Columbia. *See* 12 U.S.C. § 1821(d)(6). Based upon O'Connor's preference the case was transferred from the Northern District of California to the District of Columbia.

After the transfer, however, O'Connor moved to retransfer the case back to the Northern District of California; if venue was not proper there for a case against the FDIC, then O'Connor invited the court to dismiss the FDIC as a party. In opposition UNUM argued that it was planning to move for summary judgment and that in the interest of judicial economy the court should decide its motion before deciding O'Connor's motion to retransfer. In August 1997 the district court

granted UNUM's motion for summary judgment, holding that

> the terms of UNUM's disability benefits policy are clear and unambiguous, and . . . pursuant to the policy's terms, plaintiff was required to file her proof of claim for long term disability benefits by no later than April 7, 1992 . . . and failed to do so.

The court thereupon transferred the case against the FDIC to the Central District of California, and O'Connor appealed.

II. Analysis

O'Connor's primary argument is that the district court erred in granting summary judgment to UNUM because UNUM failed to submit any evidence that it was prejudiced by O'Connor's failure to file timely proof of her claim. Here O'Connor relies upon the so-called "notice-prejudice" rule of California, which provides:

> [A] defense based on an insured's failure to give timely notice [of a claim] requires the insurer to prove that it suffered substantial prejudice. Prejudice is not presumed from delayed notice alone. The insurer must show actual prejudice, not the mere possibility of prejudice.

Shell Oil Co. v. Winterthur Swiss Ins. Co., 12 Cal. App. 4th 715, 15 Cal. Rptr. 2d 815, 845 (Cal. Ct. App. 1993) (citations omitted); see *Clemmer v. Hartford Ins. Co.*, 22 Cal. 3d 865, 587 P.2d 1098, 1106-07, 151 Cal. Rptr. 285 (Cal. 1978) (in banc). UNUM argues not that it suffered substantial prejudice, but rather that the notice-prejudice rule is preempted by the ERISA.

The ERISA provides broadly for the preemption of "all Sate laws insofar as they may now or hereafter relate to any employee benefit plan described in section 1003(a) of this title," 29 U.S.C. § 1144(a), subject to certain

exceptions. An exception is to be found in the "saving" clause for "any law of any State which regulates insurance, banking, or securities." *Id.* § 1144(b)(2)(A).

The parties agree that the notice-prejudice rule "relates to an[] employee benefit plan" covered by the ERISA, *id.* § 1144(a), and therefore falls within the general preemption provision of the ERISA. What they dispute is whether the saving clause applies.

In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 48, 95 L. Ed. 2d 39, 107 S. Ct. 1549 (1987), the Supreme Court described the test by which we are to determine whether a state law "regulates insurance" within the meaning of the saving clause: Take a "common-sense view" of the term "regulates insurance," and look to the three factors the Court has previously identified for determining whether an activity comes within the "business of insurance" as that term is used in the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. The three factors are:

> "First, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry."

Pilot Life, 481 U.S. at 48-49 (quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 73 L. Ed. 2d 647, 102 S. Ct. 2002 (1982)); see *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 742-44, 85 L. Ed. 2d 728, 105 S. Ct. 2380 (1985).

Applying these factors to a similar long-term disability benefit plan issued by UNUM the Ninth Circuit, in *Cisneros v. UNUM Life Insurance Co. of America*, 134 F.3d 939 (1998), pet. for cert. filed, 66 U.S.L.W. 3773 (U.S. May 20, 1998) (No. 97-1867), held that the California notice-prejudice rule comes within the saving clause of,

and therefore is not preempted by, the ERISA. After first agreeing with UNUM that the employee in that case had failed to comply with the unambiguous deadline for submitting a proof of claim. *id.* at 943, the Ninth Circuit rejected UNUM's argument that the ERISA preempted the notice-prejudice rule and reversed summary judgment in favor of UNUM because the insurer had not shown substantial prejudice from the delay.

The Cisneros court held that the notice-prejudice rule was not preempted specifically because it is covered by the saving clause. With respect to the "common sense part of the test laid out in Pilot Life, the court stated:

> By requiring the insurer to prove prejudice before enforcing proof-of-claim requirements, the notice-prejudice rule dictates the terms of the relationship between the insurer and insured and so seems, as a matter of common sense, to "regulate insurance." The rule is directed specifically at the insurance industry and is applicable only to insurance contracts.

Id. at 945. With respect to the McCarran-Ferguson factors, the court held that the first factor did not favor saving the notice-prejudice rule because "it does not alter the allocation of risk for which the parties initially contracted, namely the risk of lost income from long-term disability." *Id.* at 946.* The second and third factors, however, "weighed heavily in favor" of saving the notice-prejudice rule, respectively because that rule "dictates the terms of the relationship between the insurer and the insured, and consequently, is integral to that relationship," and because it "applies only to the insurance industry." *Id.*

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* O'Connor does not argue that the notice-prejudice rule has the effect of transfering or spreading a policyholder's risk. Therefore, while we adopt the reasoning of Cisneros, we have no occasion in this case to decide whether Cisneros was correct upon that point.

The court concluded that although only two of the three McCarran-Ferguson factors favored saving the notice-prejudice rule from preemption, on balance that was enough.

> We can find no sense in concluding that this particular state law does not regulate insurance when it so clearly does. If California's rule does not regulate insurance, what does it regulate? A rote application of the risk spreading factor would work unreasoned mischief against the broad purpose of the saving clause, eliminating California's notice-prejudice insurance rule from its reach.

Id.

UNUM's primary argument against applying the notice-prejudice rule here is that a state law "regulates insurance" within the meaning of the saving clause only if all three McCarran-Ferguson factors favor that characterization—a position that the Fifth Circuit has expressly adopted, see, e.g., *Cigna Healthplan of La., Inc. v. Louisiana*, 82 F.3d 642, 650 (5th Cir. 1996); *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 107, 110 (5th Cir. 1993), and the Eleventh Circuit has implicitly followed, see *Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467, 1469 (11th Cir. 1988) (holding that statute "fails to satisfy all of the criteria of the McCarran-Ferguson Act and, thus, falls outside the ERISA saving clause"); cf., e.g., *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990) (common-law rule of contract interpretation not saved because it failed two factors); *Howard v. Gleason Corp.*, 901 F.2d 1154, 1158-59 (2d Cir. 1990) (insurance notice statute not saved because it failed common sense test and two of three factors); *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 456 (10th Cir. 1989) (unfair practices statute not saved because it failed two of three factors). In addition, UNUM relies upon *Group Life & Health Insurance Co. v. Royal Drug Co.*,

440 U.S. 205, 59 L. Ed. 2d 261, 99 S. Ct. 1067 (1979) (holding that agreements between insurer and pharmacies setting price of prescriptions is not "business of insurance" within McCarran-Ferguson Act for purpose of exemption from antitrust laws), for the proposition that the first factor—whether the rule transfers or spreads a policyholder's risk—is the most important.

These two related arguments are not persuasive. We think the better reading of the Supreme Court's McCarran-Ferguson Act cases is that none of the factors in the test is by itself determinative of what constitutes the business of insurance. Certainly nothing in Royal Drug means that any practice outside the core risk-spreading functions of insurance—such as requiring notice and proof of a claim —cannot still be a part of the "business of insurance." Indeed, in the subsequent antitrust case in which the three-factor test first appears, the Court clearly stated, albeit in a dictum, that "none of these criteria is necessarily determinative in itself." *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129, 73 L. Ed. 2d 647, 102 S. Ct. 3002 (1982). Similarly, in Metropolitan Life, where the Court first applied the McCarran-Ferguson test in order to determine whether a state law "regulates insurance" for the purpose of the ERISA saving clause, the three factors were said to be "relevant" to the question whether a state law is a regulation of the "business of insurance." 471 U.S. at 743. That the factors are merely "relevant" suggests that they need not all point in the same direction, else they would be "required."

Moreover, because the notice-prejudice rule so clearly passes the common sense part of the test set out in Metropolitan Life, we think it would be unreasonable to hold that the rule does not regulate the business of insurance because it does not transfer or spread a policyholder's risk. As the Ninth Circuit asked rhetorically in Cisneros, "if California's rule does not regulate insurance, what does

it regulate?" Furthermore, the second McCarran-Ferguson factor strongly supports the conclusion that the notice-prejudice rule regulates the business of insurance; the rule directly regulates the relationship between insurer and insured, which the Supreme Court has indicated is the "focus" of the term "business of insurance" in the McCarran-Ferguson Act. "Statutes aimed at protecting or regulating this relationship, directly or indirectly, are laws regulating the 'business of insurance.'" *SEC v. National Securities, Inc.*, 393 U.S. 453, 460, 21 L. Ed. 2d 668, 89 S. Ct. 564 (1969).

UNUM argues next that two other courts of appeals have held that ERISA preempts state notice rules, here referring to *Nazay v. Miller*, 949 F.2d 1323 (3d Cir. 1991), and *Howard v. Gleason Corp.*, 901 F.2d 1154 (2d Cir. 1990). Although the court in Nazey did hold that the district court improperly imported a state prejudice rule into the notice requirement of a health insurance plan, see 949 F.2d at 1336-37, the opinion addresses neither the preemption nor the saving provisions of the ERISA. In Howard the court determined that the state rule at issue fell outside the saving clause largely because it applied both to insurers and to employers, see 901 F.2d at 1158-59; the notice-prejudice rule of California, however, applies only to insurers. Therefore, neither Nazay nor Howard controls this case.

Finally, UNUM relies upon six cases upholding the decisions of insurers not to provide benefits to employees who failed to file timely proof of their claims. In four of the cases UNUM cites there was no issue of preempting a state noticeprejudice or similar rule. See *Shealy v. UNUM Life Ins. Co. of Am.*, 979 F. Supp. 395 (D.S.C. 1997), aff'd mem., ——— F.3d ———, 1998 U.S. App. LEXIS 8820, 1998 WL 231258 (4th Cir. 1998); *Lehmann v. UNUM Life Ins. Co. of Am.*, 916 F. Supp. 897 (E.D. Wis. 1996); *Ken-*

nedy v. System One Holdings, Inc., 835 F. Supp. 947 (S.D. Tex. 1993); *Freeman v. UNUM Life Ins. Co.*, 1990 WL 640294 (D. Minn. Mar. 27, 1990). In the other two cases the courts dismissed almost entirely without analysis the arguments that state law required a showing of prejudice. See *Oas v. Royal MacCabees Life Ins. Co.*, 1995 U.S. Dist. LEXIS 16841, 1995 WL 664640, at *7 (E.D. Pa. Nov. 6, 1995) (citing Nazay and stating that there the Third Circuit "rejected the idea of an Insurance Company having to establish some sort of prejudice"), aff'd mem., 92 F.3d 1172 (3d Cir. 1996); *Mackey v. UNUM Life Ins. Co. of Am.*, No. C86-5265, at 5 (W.D. Wash. May 12, 1987) ("State law is inapplicable in this ERISA case"). Therefore these cases do not alter our conclusion.

III. Conclusion

We hold that the ERISA does not preempt the notice-prejudice rule of California. Therefore, because UNUM did not provide evidence of substantial prejudice the district court erred when it granted UNUM's motion for summary judgment. Accordingly we remand this matter for the district court to determine whether, with UNUM still a defendant, the case should stay in the District of Columbia or be transferred elsewhere.

So ordered.

MOTION FILED

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No. 97-1868

IN THE

Supreme Court of the United States

OCTOBER TERM, 1997

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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MOTION FOR LEAVE TO FILE BRIEF AMICUS CURIAE AND BRIEF AMICUS CURIAE OF STANDARD INSURANCE COMPANY IN SUPPORT OF THE PETITION

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MOTION OF STANDARD INSURANCE COMPANY FOR LEAVE TO FILE BRIEF AMICUS CURIAE

Pursuant to Rule 37.2 of the Rules of this Court, Standard Insurance Company ("Standard") hereby moves for leave to file the attached brief *amicus curiae* in support of the petition filed by Unum Life Insurance Company of America ("Unum"). Petitioner has consented to the filing of this brief. Respondent has not consented to the filing of this brief.

Standard has a direct and substantial interest in the issues presented in the petition. Standard is one of the nation's largest providers of group long-term disability and retirement insurance, with over 60,000 group clients representing more than 4 million individual participants in many different States. The Ninth Circuit's decision

means—at a bare minimum—that claim filing deadlines in long-term disability plans insured by Standard are valid in some States but not in others, seriously undermining the uniformity and predictability in claims handling that ERISA was enacted to ensure.

Moreover, as described in greater detail in the attached brief, the impact of the Ninth Circuit's decision in this case is far broader than the specific "notice-prejudice" and "*Elfstrom*" rules at issue here. *Ward* holds, first, that a state law that indisputably affects the administration of an ERISA plan is saved from preemption as a law that "regulates insurance" even though it has nothing to do with "spreading the policyholder's risk"—which this Court has identified as an "indispensable" characteristic of insurance. *Ward* also holds that the state-law *Elfstrom* rule is not preempted because it does not "relate to" the ERISA plan at issue in this case—even though that rule abrogates express provisions of the plan and creates an agency relationship between the ERISA insurer and the plan administrator. These holdings substantially narrow the breadth of ERISA's preemption clause, subject ERISA administrators like Standard to widely varying sets of regulations from State to State, and necessarily increase the cost of supplying benefits.

For the foregoing reasons, Standard respectfully requests that this Court grant it leave to file the attached brief *amicus curiae*.

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July 10, 1998

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BRIEF AMICUS CURIAE OF STANDARD INSURANCE COMPANY IN SUPPORT OF THE PETITION

INTEREST OF THE AMICUS

Standard's interest in the issues presented by the petition is substantial and direct for the reasons set forth in the foregoing motion for leave to file this brief.* In sum,

* Pursuant to Rule 37.6, *amicus* Standard Insurance Company states that no counsel for a party has written this brief in whole or in part and that no person or entity, other than *amicus*, or its counsel, has made a monetary contribution to the preparation or submission of this brief. Petitioner has consented to the filing of this brief and their letter of consent has been filed with the Clerk of the Court. Respondent has not consented.

Standard is one of the largest providers of insurance to plans covered by ERISA and thus is necessarily affected by the lack of uniformity in ERISA preemption law and the conflicting obligations that this creates. Because the Ninth Circuit's decision in this case conflicts with the Fifth and Eleventh Circuits' decisions in *CIGNA Healthplan v. Louisiana*, 82 F.3d 642 (5th Cir. 1996), and *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467 (11th Cir. 1988), the ability of benefit plans to establish time limits for submitting claims is different in California than it is in Texas and Florida. Further, the rationale underlying the Ninth Circuit's ruling on the bounds of ERISA preemption makes it at best uncertain whether other benefit plan provisions are enforceable. Because this decision substantially undermines the predictability that ERISA was enacted to provide, Standard has a compelling interest in this Court granting the petition.

REASONS FOR GRANTING THE PETITION

The petition offers a textbook case for this Court's intervention. The Courts of Appeals are clearly divided on the important ERISA issues presented and there is no reason to suppose that the split will resolve itself. In this case, the Ninth Circuit held that a state law that relates to an employee benefit plan can be "saved" from ERISA preemption on the ground that it "regulates insurance" even though it *does not* satisfy all three of the McCarran-Ferguson Act factors for assessing whether a law regulates "the business of insurance." *Cisneros v. Unum Life Ins. Co.*, 134 F.3d 939, 944-47 (9th Cir. 1998). The Sixth Circuit agrees. *See Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 940-41 (6th Cir. 1997). The Fifth Circuit, however, has held that a state law that relates to an employee benefit plan cannot be "saved" from ERISA preemption on the ground that it "regulates insurance" unless that law satisfies *all three* of the McCarran-Ferguson Act factors. *See CIGNA Healthplan*, 82 F.3d at 650. The

Eleventh Circuit agrees. *See Anschultz*, 850 F.2d at 1469.

The Ninth Circuit also held that a state-law rule imputing an agency relationship between the plan administrator of the ERISA plan at issue in *Ward* and the plan's insurer (the so-called "*Elfstrom*" rule) was not preempted by ERISA because that state-law rule did not "relate to" the ERISA plan. This holding conflicts with *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1492-95 (7th Cir. 1996), in which the Seventh Circuit held that a comparable state-law "ostensible agency" rule "related to" the ERISA plan at issue in that case and was preempted.

There is no benefit to allowing these issues to "percolate" any longer in the lower courts: the split in authority is established and unlikely to resolve itself absent intervention by this Court. This is particularly true because the current split in authority on the insurance savings clause issue has been fostered by this Court's unelaborated statement in *Union Labor Life Ins. Co. v. Pireno* that "[n]one of [the McCarran-Ferguson] criteria is necessarily determinative in itself . . . ." 458 U.S. 119, 129 (1982).

In addition to satisfying this traditional criterion for certworthiness, this case offers the Court a good vehicle for resolving the ERISA issues presented in the petition: the issues were clearly raised and adjudicated at the trial and appellate levels, both sides of the issues will be ably briefed, and there are no procedural impediments to reaching and deciding the issues presented.

In short, this split in authority is one which the Court needs to resolve, and it should do so in this case.

I. THE CIRCUIT SPLIT REGARDING THE SCOPE OF ERISA'S "INSURANCE SAVINGS CLAUSE" IS CLEAR AND WILL NOT RESOLVE ITSELF.

In ruling that the California notice-prejudice rule is not preempted by ERISA, the *Ward* court relied directly on the Ninth Circuit's recent decision in *Cisneros v. Unum Life Insurance Co.*,[1] in which the panel candidly acknowledged the split in authority that the petition is asking this Court to resolve:

> We recognize that the Fifth Circuit has held that all three of the McCarran-Ferguson factors must be satisfied for a law to "regulate insurance." *CIGNA Healthplan of La., Inc. v. State of La.*, 82 F.3d 642, 650 (5th Cir. 1996), *cert. denied*, —— U.S. ——, 117 S. Ct. 387, 136 L.Ed.2d 304; *Tingle* [*v. Pacific Mut. Ins. Co.*,] 996 F.2d [105] at 108 [(5th Cir. 1993)]. We respectfully disagree. From our interpretation of *Metropolitan Life* [*Ins. Co. v. Massachusetts*, 471 U.S. 722 (1985)] and *Pilot Life* [*Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987)], we conclude that the McCarran-Ferguson factors are simply relevant considerations or guideposts, not separate essential elements of a three-part test that must each be satisfied for a law to escape preemption.

Cisneros, 134 F.3d at 946.

The Ninth Circuit accurately reads *CIGNA Healthplan* and *Tingle*. In both cases, the Fifth Circuit stated clearly that to fall within the "insurance savings clause" and thereby avoid ERISA preemption, a statute must satisfy all three McCarran-Ferguson criteria for regulating insurance:

[1] Petitioner Unum Life Insurance Company of America has also filed a petition for certiorari in *Cisneros*. *Cisneros* presents the same "insurance savings clause" issue as *Ward*, but does not present the additional critical issue in *Ward* regarding the types of state laws that "relate to" an ERISA plan and are therefore preempted. Standard therefore urges the Court to grant the petition for certiorari in *Ward*.

> If the statute fitted the common sense definition of insurance regulation and the court answered "yes" to each of the questions in the three part test, then the statute fell within the savings clause exempting it from ERISA preemption.
>
> * * * *
>
> Although the statute fits the common sense definition of insurance regulation, it fails to satisfy at least one prong of the three part *Metropolitan Life* test. Thus, the statute does not fall within the ERISA insurance savings clause and is, therefore, preempted by ERISA.

Tingle, 996 F.2d at 109; *see also CIGNA Healthplan*, 82 F.3d at 650 ("[I]f a statute fails to satisfy any one element of the three-factor *Metropolitan Life* test, then the statute is not exempt from preemption by the ERISA insurance savings clause").

The Sixth Circuit has recently sided with the Ninth Circuit, citing *Pireno* and the decision underlying this petition and holding that "[t]hese [McCarran-Ferguson] criteria must be considered in combination, and, standing alone, no single one is dispositive." *Davies*, 128 F.3d at 940. The Eleventh Circuit agrees with the Fifth Circuit, holding that a statute that "fails to satisfy all of the criteria of the McCarran-Ferguson Act . . . falls outside of the ERISA saving clause . . . [and] is preempted." *Anschultz*, 850 F.2d at 1469.

In light of this established split in authority, there is no good reason for the Court to await further consideration of this issue by the lower courts.

II. THE CONFUSION REGARDING THE SCOPE OF ERISA'S INSURANCE SAVINGS CLAUSE STEMS FROM AMBIGUOUS LANGUAGE IN *PIRENO*.

In *Cisneros*, the Ninth Circuit properly recognized that the California notice-prejudice rule at issue in this case does not have "the effect of transferring or spreading a

policyholder's risk," the first of the McCarran-Ferguson criteria for assessing whether a statute "regulates insurance":

> In this regard, the notice-prejudice rule is different from the Massachusetts mandatory benefits law at issue in *Metropolitan Life*. That law altered the substantive scope of coverage that Massachusetts insurance companies contractually were obligated to provide. Thus, unlike the statute in *Metropolitan Life*, the notice-prejudice rule does not spread the policyholder's risk within the meaning of the first McCarran-Ferguson factor.

Cisneros, 134 F.2d at 946.

Nevertheless, the *Cisneros* court ruled that the notice-prejudice rule fell within ERISA's "insurance savings clause" by reading this Court's ERISA decisions to hold that "the McCarran-Ferguson factors are simply relevant considerations or guideposts, not separate essential elements of a three-part test that must each be satisfied for a law to escape preemption." 134 F.2d at 946. In support of this determination—the heart of the Circuit split the petition is asking this Court to resolve—the *Cisneros* court stated:

> Indeed, in cases interpreting the McCarran-Ferguson Act—from which the factors were born—the Supreme Court has explicitly noted that "none of [the factors McCarran-Ferguson factors] is necessarily determinative."

134 F.3d at 946 (citing *Pireno*, 458 U.S. at 129).

The Ninth Circuit broadly read this somewhat ambiguous statement in *Pireno* to make each of the McCarran-Ferguson criteria—including the risk spreading feature that the *Cisneros* court acknowledged was absent in the notice-prejudice rule at issue—*dispensable* in the insurance savings clause analysis. This reasoning runs contrary to this Court's unambiguous statements in *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205 (1979),

that: (1) "The *primary* elements of an insurance contract are the spreading and underwriting of a policyholder's risk" (*Id.* at 211) (emphasis supplied); (2) "The significance of underwriting or spreading of risk as an *indispensable* characteristic of insurance was recognized by this Court in *SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65" (*Id.* at 212) (emphasis supplied); and (3) "The petitioners do not really dispute that the underwriting or spreading of risk is a *critical determinant* in identifying insurance." *Id.* at 213.

Although the Ninth Circuit's rulings in *Ward* and *Cisneros* are inconsistent with this Court's holding in *Royal Drug Co.*, the critical point is that the root of the confusion that produced the decisions in *Ward* and *Cisneros* (and the Circuit conflict on the important ERISA preemption issue presented in the petition) is ambiguous language in *Pireno* which *only* this Court can clarify.

III. THE COURT ALSO SHOULD RESOLVE THE LINGERING CONFUSION REGARDING THE TYPES OF STATE LAWS THAT "RELATE TO" AN ERISA PLAN AND ARE THEREFORE PREEMPTED.

The Ninth Circuit's decision in *Ward* also provides this Court with an opportunity to address another critical ERISA preemption issue that has divided the Circuits—the types of state laws that "relate to" an ERISA plan and therefore are preempted by ERISA. In *Ward*, the Ninth Circuit held that a state-law rule (the *Elfstrom* rule)[2] creating an agency relationship between the ERISA plan insurer (Unum) and the plan administrator (respondent's employer Management Analysis Company ("MAC") did not "relate to" the plan because the rule had only a "tenuous" connection to the plan:

> While § 514(a)'s language is "deliberately expansive," *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 46 (1987), ERISA does not preempt "if the state

[2] The rule derives from *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503 (1967).

law has only a 'tenuous, remote, or peripheral' connection with covered plans, . . . as is the case with many laws of general applicability . . . ." *District of Columbia v. Greater Washington Bd. of Trade*, 506 U.S. 125, 130 n.1 (1992) (quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 100 n.21 (1983)). . . . The Supreme Court recently acknowledged the existence of "myriad state laws in areas traditionally subject to local regulation, which Congress could not possibly have intended to eliminate." *California Div. of Labor Satndards Enforcement v. Dillingham Constr.*, 117 S.Ct. 832, 842 (1997).

* * * *

ERISA and *Elfstrom* are not anathema. *Elfstrom* does not dictate the benefits to be provided or the manner in which the plan will be administered. *Elfstrom* does not require an employer to participate in the administration of a group insurance policy or an insurer to delegate its functions to an employer. . . . *Elfstrom* simply describes in legal terms a relationship that already exists in fact.

Ward, 135 F.2d at 1287 (parallel cites omitted).

The Ninth Circuit recognized that the plan documents at issue in *Ward* provided specifically that "[u]nder no circumstances will the policyholder [MAC] be deemed the agent of the Company [UNUM] without a written authorization." *Id.* at 1284. But, the *Ward* court concluded that even though it was holding that *Elfstrom* overruled this plan provision, *Elfstrom* did not relate to the plan because "[p]lan documents defining or disavowing a relationship do not have the status of the ERISA statute . . . ." *Id.* at 1288.

In direct contrast, the Seventh Circuit applied the same precedent and ruled in *Jass* that a state-law rule creating an agency relationship between an ERISA plan and a treating physician under the plan "related to" the plan and was preempted:

> In this case, both of Jass' vicarious liability claims against PruCare for Dr. Anderson's alleged negligence (Counts I and II) directly "relate to" the Plan. . . . If an agency relationship existed between PruCare and Dr. Anderson, as Jass alleged, it was solely as a result of the PruCare's health plan of which Jass was a participant. . . . Additionally, to determine whether an actual or apparent relationship existed between Dr. Anderson and PruCare would require an examination of the health care benefit plan to determine the relationship between Dr. Anderson, PruCare and Jass. In fact, the health benefit plan contains a section entitled "relation among the parties affected by the group contract," which states that no participating physician is an employee or agent of PruCare. We note this not to resolve the question of agency, but to highlight that Jass' claims "relate to" the health benefit plan.

Jass, 88 F.3d at 143.

The decisions in *Ward* and *Jass* are irreconcilable: the very factors that the Seventh Circuit found determinative of the preemption inquiry were deemed inconsequential by the Ninth Circuit. Although Standard believes that the *Ward* court misapprehended this Court's ERISA precedent and, in particular, read *Dillingham* much too broadly, the critical point is that in spite of this Court's efforts to clarify the meaning of "relates to" in Section 514(a) of ERISA, the Circuits remain confused. *Dillingham* did not purport to change the law. Yet, the Ninth Circuit has read that case as somehow narrowing the Court's long-standing view that Section 514(a)'s preemption clause is "deliberately expansive" (*Pilot Life*, 481 U.S. at 46) and "conspicuous for its breadth." *FMC Corp. v. Holliday*, 498 U.S. 52, 58 (1990). As with the "insurance savings clause" issue, this confusion is something that only this Court can resolve.

IV. THE ISSUES PRESENTED ARE OF WIDESPREAD SIGNIFICANCE.

The bottom line is that the Circuits have adopted irreconcilable positions on the types of state laws affecting employee benefit plans that survive ERISA preemption.

The unavoidable result of these inconsistent rulings is the precise "patchwork scheme of regulation" which ERISA's broad preemption provision was enacted to eliminate and thereby increase efficiency and reduce the cost of providing benefits. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987). The Court has recognized that subjecting benefit providers to disparate legal regimes increases the risk that employers will opt not to offer certain benefits to their employees. *See id.* Varying court rulings on the status of statutes like the California notice-prejudice rule at issue here will compel benefit providers to

> design their programs in an environment of differing State regulations[, which] would complicate the administration of nationwide plans, producing inefficiencies that employers might offset with decreased benefits.

FMC Corp., 498 U.S. at 60.

This is the risk Congress intended to avoid in enacting ERISA. By granting the petition and reversing the Ninth Circuit's decision, this Court will ensure the uniformity of law essential to effective cost containment and the correlative increase in the availability of benefits to plan beneficiaries.

CONCLUSION

For the foregoing reasons, this Court should grant the petition.

Respectfully submitted,

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ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE* AND BRIEF *AMICI CURIAE* OF AMERICAN COUNCIL OF LIFE INSURANCE, HEALTH INSURANCE ASSOCIATION OF AMERICA, AETNA LIFE INSURANCE COMPANY, CONNECTICUT GENERAL LIFE INSURANCE COMPANY, LIFE INSURANCE COMPANY OF NORTH AMERICA, INSURANCE COMPANY OF NORTH AMERICA, AND INA LIFE INSURANCE COMPANY OF NEW YORK IN SUPPORT OF THE PETITIONER

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IN THE

SUPREME COURT OF THE UNITED STATES

OCTOBER TERM, 1997

No. 97-1868

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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MOTION FOR LEAVE TO FILE BRIEF *AMICI CURIAE*

The American Council of Life Insurance represents the interests of more than 500 member life insurance companies that together underwrite the vast majority of disability and life insurance in the United States. The Health Insurance Association of America is an advocate for the private market-based health insurance system, representing more than 200 members which provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to more than 65 million Americans.

Aetna Life Insurance Company, Connecticut General Life Insurance Company, Life Insurance Company of North America, Insurance Company of North America, and INA Life Insurance Company of New York are among the largest insurance companies in the United States. They are major nationwide providers of disability, life and other group insurance to employee benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA").

The petition in this case presents two questions of vital interest to these *amici* relating to the scope of ERISA's preemption of state law. The Ninth Circuit's decision in this case permits state law to apply to claims for benefits under ERISA-covered employee benefit plans and thus undermines the uniform federal regulation that Congress intended to create by enacting ERISA's preemption provision. Many of the employee benefit plans served by *amici* or their members are administered on a multistate or even nationwide basis. The practical effect of the Ninth Circuit's decision, unless reviewed and reversed by this Court, will be to increase the complexity and cost of administering these plans to conform to varying state rules, thus making it likely that employers will decide either not to offer these types of benefits to employees or to offer benefits on a less generous basis than they currently do.

Therefore, *amici* request this Court to accept the attached brief in support of the petition for certiorari in this case. Petitioner has consented to the filing of this brief; respondent has not consented.

Respectfully submitted,

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July 20, 1998

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BRIEF *AMICI CURIAE* OF AMERICAN COUNCIL OF LIFE INSURANCE, HEALTH INSURANCE ASSOCIATION OF AMERICA, AETNA LIFE INSURANCE COMPANY, CONNECTICUT GENERAL LIFE INSURANCE COMPANY, LIFE INSURANCE COMPANY OF NORTH AMERICA, INSURANCE COMPANY OF NORTH AMERICA, AND INA LIFE INSURANCE COMPANY OF NEW YORK IN SUPPORT OF PETITIONER

INTEREST OF *AMICI CURIAE*[1]

The interest of the *amici curiae* is set forth in the motion accompanying this brief.

REASONS FOR GRANTING THE WRIT

The petition in this case presents two questions concerning the scope of preemption of state law by the federal Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001, *et seq*. Because these questions are recurring and important ones as to which the circuit courts have disagreed, review by this Court is warranted.

Respondent Ward was a participant in an employee welfare benefit plan sponsored by his employer, Management Analysis Company, and subject to ERISA. (Pet. 2a, 52a.) Ward's employer purchased an insurance policy issued by UNUM Life Insurance Company of America ("UNUM") to provide plan benefits, and contracted with UNUM for administrative and claims processing services for the plan. (Pet. 41a-51a.) Ward's claim for long term disability benefits under the plan was denied as untimely because it was not filed within the deadline set in the plan and in the insurance policy. (Pet. 3a.) The district court granted summary judgment dismissing Ward's suit to obtain benefits

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[1] Pursuant to Rule 37.6, *amici curiae* state that this brief was not authored, in whole or in part, by counsel to a party and that no monetary contribution to the preparation or submission of this brief was made by any person or entity other than the *amici curiae* or their counsel.

and held that his failure to meet the plan's unambiguous filing deadline disposed of his claim. (Pet. 4a.)

The Ninth Circuit reversed, setting forth two alternative routes through which Ward might recover -- despite the plan's terms -- through the application of principles of California common law. First, following a recent decision by the same panel in *Cisneros v. UNUM Life Insurance Co.*, 134 F.3d 939 (9th Cir. 1998), *pet. for cert. filed*, 66 U.S.L.W. 3773 (U.S. May 20, 1998) (97-1867), the Ninth Circuit applied the "notice-prejudice" rule adopted by California courts. (Pet. 5a.) Under this rule, UNUM may give effect to the plan's filing deadline only if it can demonstrate actual prejudice from Ward's late filing of his claim. Second, and alternatively, the Ninth Circuit held that the "*Elfstrom* rule" adopted by the California courts prior to ERISA -- under which an employer that arranges for a group insurance policy to provide benefits to employees may be deemed the insurer's agent -- could permit Ward to prevail contrary to the plan terms and even if UNUM could show actual prejudice from the late filing. (Pet. 24a-25a.)

The Ninth Circuit's decision both creates new conflicts with decisions of other circuits and magnifies existing conflicts over the interpretation of ERISA preemption. The court's holding that the California notice-prejudice rule is saved from preemption expands a multifaceted conflict among the circuits over the interpretation of ERISA's insurance saving clause. Its application of California's *Elfstrom* rule of agency revives and deepens a conflict over the threshold preemption issue of whether state law rules may be applied to claims seeking benefits under ERISA

plans. Absent review by this Court, these conflicts are likely to grow, not recede.

Review by this Court is also warranted because the Ninth Circuit's decision undermines the congressional intent that employee benefit plans be subject to exclusively federal regulation. As this Court has recognized many times, ERISA's "deliberately expansive" preemption provision, *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 45-46 (1987), was intended to displace a patchwork of varying state regulation and clear the field for uniform federal regulation, *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 11 (1987). The decision below undoes that federal uniformity in two ways. On the one hand, its application of the California notice-prejudice rule greatly expands the scope of the principal statutory exemption from preemption by holding that a common law rule may be saved from preemption as a law which regulates insurance. On the other hand, its application of California's *Elfstrom* rule of agency narrows the basic scope of preemption by holding that a state law rule that is directly applied to alter an employee benefit plan's terms nonetheless does not "relate to" the plan for preemption purposes. The Ninth Circuit's decision thus chops ERISA preemption from both ends and subjects employee benefit plans to a wide variety of state regulation.

In enacting ERISA, Congress found that "the operational scope and economic impact of [employee benefit] plans is increasingly interstate." *See* ERISA § 2(a), 29 U.S.C. § 1001(a). The interstate nature of plans has only increased in the more than two decades since that finding. Many plans operate in more than one state, and large plans may be administered on a nationwide basis. To subject these plans,

as the Ninth Circuit decision does, to differing regulation in fifty states will make uniform plan operation impossible and greatly increase the complexity and cost of plan administration. ERISA's preemption provision was designed to avoid exactly these consequences. Accordingly, to resolve the circuit conflicts and preserve the uniformity of federal regulation, the petition should be granted.

I. REVIEW IS WARRANTED TO RESOLVE CONFLICTS AMONG THE CIRCUITS OVER INTERPRETATION OF ERISA'S INSURANCE SAVING CLAUSE

Section 514(a) of ERISA, 29 U.S.C. § 1144(a), provides generally that the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan" subject to ERISA. A state law that meets this threshold standard for preemption because it "relate[s] to" an ERISA plan may nonetheless be "saved" from preemption under § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), if it is a law "which regulates insurance, banking, or securities." In *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724, 740-43 (1985), this Court held that whether a law "regulates insurance" for purposes of this insurance saving clause should be determined in light of a "common sense" definition of insurance regulation as well as consideration of the three factors developed by this Court for determining whether a state law regulates the business of insurance under the McCarran-Ferguson Act. *See also Pilot Life*, 481 U.S. at 50-51.

The Ninth Circuit's holding that California's common law notice-prejudice rule is saved from ERISA preemption by virtue of the insurance saving clause rested on an earlier

decision by the same panel of that court in *Cisneros*. As discussed below, the Ninth Circuit's construction of ERISA's insurance saving clause conflicts with decisions of other courts of appeal in multiple significant ways.

A. A Conflict Exists Over Whether a State Law Must Satisfy All of the McCarran-Ferguson Factors to Fall Within the Saving Clause

In *Cisneros*, the Ninth Circuit acknowledged that the notice-prejudice rule did not satisfy the first of the three factors developed under the McCarran-Ferguson Act for determining whether a state law regulates the business of insurance, *i.e.*, whether the state law affects the transfer or spreading of risk. 134 F.3d at 945-46. The court held, however, that it was not necessary for a state law to satisfy all three of the McCarran-Ferguson factors in order to fall within the insurance saving clause, concluding instead that the factors are "simply relevant considerations or guideposts." *Id.* at 946.

The Ninth Circuit recognized that its holding directly conflicts with two decisions from the Fifth Circuit, *Tingle v. Pacific Mutual Insurance Co.*, 996 F.2d 105, 108, 110 (5th Cir. 1993), and *CIGNA Healthplan of La., Inc. v. Ieyoub*, 82 F.3d 642, 650 (5th Cir. 1996), *cert. denied*, 117 S. Ct. 387 (1997). *Cisneros*, 134 F.3d at 946. This conflict has subsequently deepened as a result of the decisions in *Davies v. Centennial Life Insurance Co.*, 128 F.3d 934, 940 (6th Cir. 1997) and *O'Connor v. UNUM Life Insurance Co.*, No. 97-5244, 1998 U.S. App. LEXIS 15117 (D.C. Cir. July 7, 1998), in which the Sixth and D.C. Circuits, respectively, noted the circuit conflict and elected to follow *Cisneros*. As the D.C. Circuit stated:

> UNUM's primary argument against applying the notice-prejudice rule here is that a state law "regulates insurance" within the meaning of the saving clause only if all three McCarran-Ferguson factors favor that characterization -- a position that the Fifth Circuit has expressly adopted, *see, e.g., CIGNA Healthplan of La., Inc. v. Ieyoub; Tingle v. Pacific Mut. Ins. Co.*, and the Eleventh Circuit has implicitly followed, *see Anschultz v. Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467, 1469 (11th Cir. 1988).

O'Connor, 1998 U.S. App. LEXIS 15117, at *11 (citations and parentheticals omitted). A conflict over this issue is particularly significant, since lower court decisions are likely to continue to diverge in their interpretation of the insurance saving clause if they cannot agree what weight to accord to particular McCarran-Ferguson factors.

Moreover, absent this Court's intervention, it is unlikely that this conflict will resolve itself. The Ninth, Sixth and Fourth Circuits have relied on this Court's statement in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982), that "[n]one of the [McCarran-Ferguson factors] is necessarily determinative in itself." *Cisneros*, 134 F.3d at 946; *Davies*, 128 F.3d at 940; *Stuart Circle Hosp. Corp. v. Aetna Health Mgmt.*, 995 F.2d 500, 503 (4th Cir.), *cert. denied*, 510 U.S. 1003 (1993). However, *Pireno*, an antitrust case involving whether use of a peer review committee to advise insurers about the reasonableness of chiropractors' charges was part of the business of insurance, never reached the question presented here; because the Court found that the practice failed to satisfy any of the three

McCarran-Ferguson factors, it had no occasion to decide whether all three McCarran-Ferguson factors must be satisfied. Similarly, in *Pilot Life Insurance Co. v. Dedeaux*, the Court also was not required to address this issue because the state law in question there "at most [met] one of the three criteria." 481 U.S. at 51. Accordingly, absent a definitive resolution by this Court, the direct conflict in the circuits over this issue will persist.

B. A Conflict Exists Over the Application of the McCarran-Ferguson Factors in Construing ERISA's Saving Clause

In addition to the acknowledged conflict over whether all three McCarran-Ferguson factors must be met, the decision below and its companion decision in *Cisneros* also conflict with decisions from other circuits regarding the proper application of each of the three McCarran-Ferguson factors.

1. Effect on Risk Spreading

The first McCarran-Ferguson factor is whether the state law affects the transfer or spreading of policyholder's risk. *Metropolitan Life*, 471 U.S. at 743. In *Cisneros*, the Ninth Circuit concluded that the California notice-prejudice rule "regulates insurance" even though the rule does not satisfy this factor. 134 F.3d at 946. This conclusion conflicts with decisions of this Court and circuit courts that have viewed risk spreading as essential to the business of insurance.

In *Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205, 212-213 (1979), this Court characterized the "underwriting or spreading of risk" as "an indispensable characteristic" and "a critical determinant in identifying" insurance. *See also Barnett Bank of Marion County, N.A. v.*

Nelson, 116 S. Ct. 1103, 1112 (1996) (noting that spreading of risk is "at the core of the McCarran-Ferguson Act's concerns"). Other circuits have applied this principle in interpreting ERISA's insurance saving clause. For example, in *Anderson v. Humana Inc.*, 24 F.3d 889, 892 (7th Cir. 1994), the Seventh Circuit stated that "'[i]nsurance' under McCarran-Ferguson requires some component of risk pooling, and the sort of regulation preserved to the domain of the states [by ERISA's saving clause] is that expressly directed at that insurance component -- as opposed to, say, laws of general application that just happen to have some bearing on the affairs of insurers." Similarly, in *Tingle*, 996 F.2d at 108, the Fifth Circuit concluded that a state law could not regulate insurance for purpose of ERISA's insurance saving clause because it did not affect the spreading of risk.

The Ninth Circuit in *Cisneros*, however, took a flatly inconsistent approach. After conceding that California's notice-prejudice rule may not "have the effect of transferring or spreading the policyholder's risk," the court nonetheless held that the notice-prejudice rule was saved as a law which regulates insurance, rejecting a "rote application of the risk-spreading factor." *Cisneros*, 134 F.3d at 945-46. This rationale was recently followed by the D.C. Circuit in *O'Connor*, 1998 U.S. App. LEXIS 15117, at *7-*8. Because these decisions cannot be squared with the decisions of the Seventh and Fifth Circuits or of this Court, review by this Court is appropriate.

2. Effect on an Integral Part of the Insurer-Insured Relationship

The Ninth Circuit attempted to justify its rejection of the significance of the risk-spreading factor by analogizing California's notice-prejudice rule to a mandated benefits law, such as the law held saved from preemption by this Court in *Metropolitan Life Insurance Co. v. Massachusetts*, 471 U.S. 724 (1984). The Ninth Circuit viewed the California rule as "effectively creat[ing] a mandatory contract term," satisfying the second McCarran-Ferguson factor, *i.e.*, whether the state law at issue affects an integral part of the relationship between insurer and insured. *Id.* Thus, the court stated that it "failed to discern much difference on one hand between forcing minimum healthcare benefits into contracts that do not contain them and subjecting contracts to a notice-prejudice rule on the other." *Cisneros*, 134 F.3d at 946.

In so stating, the Ninth Circuit remarked on an obvious distinction between the Massachusetts mandated benefits statute at issue in *Metropolitan Life* and the California notice-prejudice rule. The Massachusetts law directly affected a substantive term of the insurance contract by requiring that certain benefits be included in the contract, while the California rule merely shifted the legal risks that would be faced when a claim was asserted under the contract. In *Pilot Life*, this Court recognized the significance of this distinction, noting that the Mississippi law of bad faith at issue there "did not define the terms of the relationship between the insurer and the insured" but merely provided a remedy if the insurer breached the contract in bad faith. 481 U.S. at 51.

If the Ninth Circuit's analysis were followed, then virtually any procedural rule or remedy affecting an insured employee benefit plan could be saved from preemption as a law which regulates insurance. Moreover, the Ninth Circuit's analysis, now joined by the D.C. Circuit in *O'Connor*, creates yet another conflict with decisions of other circuits regarding interpretation of the second McCarran-Ferguson factor, that is, whether a purely administrative contract term can be considered an integral part of the relationship between the insurer and insured.

In *Smith v. Jefferson Pilot Life Insurance Co.*, 14 F.3d 562 (11th Cir.), *cert. denied*, 513 U.S. 808 (1994), the Eleventh Circuit addressed a claim by an ERISA plan beneficiary based on an alleged violation of a Georgia statute that required written notice for cancellation of insurance coverage to be effective. As part of its holding that the Georgia statute was not saved from preemption, the Eleventh Circuit concluded that the statute did not satisfy the second McCarran-Ferguson factor because it "regulates the administration of policies, not their substantive terms." 14 F.3d at 570. Similarly, in *Davies*, 128 F.3d at 942, the Sixth Circuit held that a state law permitting rescission of coverage in the case of willful misrepresentation by an ERISA plan participant was not saved from preemption and could not be applied to defeat the claim of that participant. Like the Eleventh Circuit in *Smith*, the Sixth Circuit held that the state statute did not satisfy the second McCarran-Ferguson factor because it did not "affect the substantive terms of" the insurance contract. *Id.* These decisions from the Eleventh and Sixth Circuits cannot be reconciled with the Ninth Circuit and D.C. Circuit decisions, warranting review by this Court.

3. Limitation to the Insurance Industry

The decision below also conflicts with decisions from other circuits regarding the third McCarran-Ferguson factor, *i.e.*, whether the state law at issue is limited to entities in the insurance industry. *Metropolitan Life*, 471 U.S. at 743. The Ninth Circuit's discussion of this factor in *Cisneros* was brief and conclusory. Thus, said the Ninth Circuit, the "third McCarran-Ferguson factor is satisfied because the notice-prejudice rule applies only to the insurance industry." *Cisneros*, 134 F.3d at 946. *Accord*, *O'Connor*, 1998 U.S. App. LEXIS 15117, at *8.

Other circuits have, however, applied this Court's analysis in *Pilot Life Insurance Co. v. Dedeaux* to reach a different conclusion. In *Pilot Life*, the Court held that the Mississippi law of bad faith, although "identified" and "associated with the insurance industry," did not satisfy the third McCarran-Ferguson factor because it "developed from general principles of tort and contract law available in any Mississippi breach of contract case." 481 U.S. at 50-51.

Both the Sixth and Seventh Circuits have followed *Pilot Life* to hold, in direct conflict with the decision below, that state common law doctrines available only against insurers did not satisfy the third McCarran-Ferguson factor. Thus, in *Schachner v. Blue Cross and Blue Shield of Ohio*, 77 F.3d 889, 897-98 (6th Cir.), *cert. denied*, 117 S. Ct. 173 (1996), the court held preempted an action based on an Ohio tort cause of action for a bad faith breach of an insurance contract. The Sixth Circuit explained that "the tort claim against an insurer for a bad faith refusal to pay a claim does not exist independent of traditional, generally-applicable common law; rather, it exists simply because of the Ohio

courts' determination that the relationship between insurer and insured gives rise to a fiduciary duty and that a breach of that duty is tortious." Similarly, in *Smith v. Blue Cross & Blue Shield United of Wisconsin*, 959 F.2d 655, 657-58 (7th Cir. 1992), the Seventh Circuit held that a claim based on a Wisconsin "cause of action in tort against an insurer for the bad faith refusal to honor a claim of the insured" was not saved under the third McCarran-Ferguson factor because it involved only "a typical tort case" that "relied on standard contract principles." *See also Gaylor v. John Hancock Mut. Life Ins. Co.*, 112 F.3d 460, 466 (10th Cir. 1997) (holding that a bad faith claim based on an Oklahoma statute that was "specifically directed at the insurance industry" was nonetheless preempted since the statute's "origins are from general principles of tort and contract law.")

In deciding that the notice-prejudice rule was specifically directed at the insurance industry, the Ninth Circuit made no attempt to explore the common law roots of the rule.[2] Its decision not to do so placed it in direct conflict with those courts that have found the common law nature of a state law to be dispositive of the analysis of the third McCarran-Ferguson factor.

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[2] The notice-prejudice rule was adopted by the California Supreme Court in *Campbell v. Allstate Insurance Co.*, 384 P.2d 155 (Cal. 1963), following lower court decisions that had derived the rule from general principles of contract law. *See, e.g., Reed v. Pacific Indemnity Co.*, 225 P.2d 255 (Cal. App. 1950) (basing adoption of rule on the principle that the intent of contracting parties should be given effect).

II. REVIEW IS WARRANTED TO RESOLVE A CIRCUIT CONFLICT OVER WHETHER A STATE LAW THAT IS APPLIED TO ALTER THE TERMS OF AN ERISA PLAN "RELATES TO" THAT PLAN FOR PREEMPTION PURPOSES

The circuit conflict over interpretation of ERISA's insurance saving clause that is the subject of this petition arises from the *Cisneros* decision, which was followed by the court below in *Ward*. What makes the *Ward* decision particularly appropriate for review by this Court is that it separately revives and deepens a circuit split over the threshold test for ERISA preemption.

In *Ward*, the Ninth Circuit, relying on a 1985 decision from the Fifth Circuit, held that the application of California's common law *Elfstrom* rule of agency in deciding a claim for benefits under an ERISA plan was not preempted because the rule did not "relate to" the plan. (Pet. 24a.) In so holding, the Ninth Circuit placed itself squarely in conflict with circuits that have read this Court's 1987 decision in *Pilot Life* as requiring the conclusion that the application of a state law rule to a plan "relates to" the plan and falls within ERISA's preemption clause. *See Pilot Life*, 481 U.S. at 47.

In *Elfstrom v. New York Life Insurance Co.*, 67 Cal.2d 503 (1967), the California Supreme Court held that an employer that purchases a group insurance policy to provide benefits to employees may, if it exercises administrative functions with respect to the group insurance program, become an agent of the insurer. The Ninth Circuit below held that the *Elfstrom* rule could be applied to find that UNUM had notice of Ward's claim within the plan's notice

period because his employer knew of the injury that gave rise to his claim. (Pet. 24a.) The Ninth Circuit reached this conclusion despite policy terms that expressly disclaimed such an agency relationship.

In holding that ERISA did not preempt the application of the *Elfstrom* rule of agency, the Ninth Circuit relied heavily on the rationale of a 1985 Fifth Circuit opinion, *Turrill v. Life Insurance Co. of North America*, 753 F.2d 1322 (5th Cir. 1985). In *Turrill*, the Fifth Circuit looked to the employer's fiduciary responsibilities under ERISA as requiring the employer to perform administrative functions with respect to a group insurance program. The Fifth Circuit held that "proof of an employer's ERISA-based reporting and fiduciary responsibilities with respect to a group insurance policy in itself raises an issue under Texas law as to the existence of an agency relationship between the employer and the group insurer." *Id.* at 1325.

As the Ninth Circuit noted, with perhaps unintentional irony, "[n]othing in *Turrill* even hints that state agency law is somehow preempted by ERISA." (Pet. 18a.) Indeed, *Turrill* did not even address the possibility that ERISA might preempt a state law rule that alters plan terms and would permit a recovery that was otherwise unavailable under ERISA. The Ninth Circuit, however, relied on Turrill to conclude that application of the *Elfstrom* rule to the plan at issue in this case does not "relate to" the plan. Rather, stating that, "ERISA and *Elfstrom* are not anathema," the Ninth Circuit concluded that ERISA's imposition of fiduciary duties on an employer who performs administrative responsibilities regarding an ERISA plan "meshes smoothly" with the state law rule adopted in *Elfstrom*. (Pet. 21a-22a.)

The decision below and the Fifth Circuit's decision in *Turrill*, however, directly conflict with decisions of this Court as well as of other circuits. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 139 (1990), this Court held that a state law claim for wrongful discharge to prevent the employee from attaining benefits under an ERISA plan was preempted because "the existence of a pension plan is a critical factor in establishing liability" under the state law. Likewise, a California common law rule of agency that premises an agency relationship upon the exercise of administrative responsibilities under an ERISA plan must "relate to" that plan. Similarly, in *Howard v. Gleason Corp.*, 901 F.2d 1154 (2d Cir. 1990), the court considered a New York statute that required employers to provide specified notice to terminated employees about insurance conversion privileges. The Second Circuit held that the state law was preempted because it "purports to impose on an employer obligations of the same general type as those imposed by ERISA." *Id.* at 1157. Rejecting the argument that the New York law should not be preempted because it "does not conflict with any express provision of ERISA in the sense that both laws could be enforced side by side," the Second Circuit held that the state statute was preempted because it "intrudes into an area that Congress intended to be fully occupied by federal statute." *Id.* at 1158. *See also Jass v. Prudential Health Care Plan*, 88 F.3d 1482, 1493 (7th Cir. 1996).

Likewise, here, California's agency principles cannot be applied to claims for benefits under ERISA plans, regardless of whether they "mesh smoothly" with ERISA's rules. By holding to the contrary, the Ninth Circuit created a conflict over the application of state law rules in deciding ERISA

claims. In order to reverse this decision and restore the exclusivity of federal law as a source of uniform regulation of employee benefit plans, review by this Court is appropriate.

CONCLUSION

For the foregoing reasons, *amici* urge this Court to grant the petition and reverse the decision below.

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July 20, 1998

MOTION FILED

JUL 20 1998

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No. 97-1868

In The

Supreme Court of the United States

October Term, 1997

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

JOHN E. WARD,

Respondent.

On Petition For A Writ Of *Certiorari*
To The United States Court Of Appeals
For The Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF FOR THE ASSOCIATION OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANIES AS *AMICUS CURIAE* AND BRIEF AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE BRIEF FOR THE ASSOCIATION OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANIES AS *AMICUS CURIAE*

Pursuant to Rule 37.2 of the Rules of this Court, the Association of California Life and Health Insurance Companies ("ACLHIC") respectfully requests leave to file the accompanying brief as *amicus curiae* in support of petitioner. Counsel for petitioner has consented to the filing of this *amicus curiae* brief. Counsel for respondent has not consented to the filing of this brief.

ACLHIC is a non-profit association whose members are domestic California life and health insurance companies and foreign life and health insurance companies which do business in California. One of the primary purposes of ACLHIC is to represent the interests of its members and their policyholders in substantial public policy matters which affect them. ACLHIC has participated as *amicus curiae* in other federal cases for this purpose. ACLHIC has a duty to promote the solvency and efficiency of its members and of the soundness of the products they issue.

In the instant case, ACLHIC has a substantial interest in insuring the efficient administration of life and health insurance policies issued to employee benefit plans subject to the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. Sections 1001, *et seq.* The interposition of disparate state common law rules of general application, such as the California notice-prejudice rule, in the administration of such plans is contrary to the express terms of ERISA and of prior decisions of this Court. The application of such rules to ERISA plans generally will

result in inefficient state-by-state benefit determinations, to the detriment of participants, beneficiaries, plan sponsors and service providers such as the members of ACLHIC. Moreover, the particular common law doctrine in question here – the California notice-prejudice rule – would unpredictably extend liability for tardy claims, prevent the reliable closing of annual records and provide disparate benefits to plan beneficiaries who reside in different states.

ACLHIC is familiar with the questions involved in the case and the scope of their presentation. ACLHIC believes that additional argument should be presented on one aspect of the legal analysis of the decision below. While petitioner has fully analyzed and briefed the legal issues presented, additional briefing by ACLHIC will assist the Court by demonstrating the errors of law of the decision below.

It is therefore respectfully requested that the motion of ACLHIC for leave to file the attached brief as *amicus curiae* be granted.

Respectfully submitted,

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July 20, 1998

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INTEREST OF THE AMICUS

The Association of California Life and Health Insurance Companies ("ACLHIC") is a non-profit association whose members are domestic California life and health insurance companies and foreign life and health insurance companies which do business in California. Its interest in the issues presented by the petition is substantial and directly affect its members for the reasons set forth in the foregoing motion for leave to file this brief.[1]

The Ninth Circuit's decision in this case conflicts with *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 471 U.S. 41, 48-50 (1987), because, without analysis or explanation, it applies a common law doctrine of general application as if it were a law specifically directed at the insurance industry. The result is to invalidate ERISA benefit plan rules requiring the timely submission of claims and to complicate the administration and expense of such plans, to the ultimate detriment of the plans and their participants.

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[1] Pursuant to Rule 37.6, *amicus* ACLHIC states that no counsel for a party has written this brief in whole or in part and that no person or entity, other than *amicus*, or its counsel, has made a monetary contribution to the preparation or submission of this brief. Petitioner has consented to the filing of this brief. Respondent has not consented.

REASONS FOR GRANTING THE PETITION

I. "Notice-Prejudice" is a Rule of General Application.

In this action, the Ninth Circuit held that California's common law notice-prejudice rule is within the scope of ERISA preemption as a state law which "related to" an employee benefit plan. ERISA Section 514(a), 29 U.S.C. Section 1144(a). The Ninth Circuit erred, however, in its conclusion that the notice-prejudice rule is a state law regulating insurance which could be "saved" from ERISA preemption under ERISA Section 514(b)(2)(a), 29 U.S.C. Section 1144(b)(2)(a). In this decision, the Ninth Circuit followed its earlier and similarly erroneous decision in *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939 (9th Cir. 1998).

In *Cisneros*, the Ninth Circuit analyzed *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 471 U.S. 41, 48-50 (1987), to the effect that state laws are saved from ERISA preemption if the law is "specifically directed" at the insurance industry and if it "regulates insurance", *Cisneros*, 134 F.3d at 944-945.

The Ninth Circuit failed, however, correctly to apply the common sense test of *Dedeaux* that such a law must be "specifically directed" at the insurance industry. On the contrary, the notice-prejudice rule is one of common application to a wide variety of situations and entities. The broadest expression of this commonplace doctrine may be found in the Restatement of the Law Second, Contracts 2d, Section 229, as follows:

> To the extent that the non-occurrence of a condition would cause disproportionate forfeiture, a court may excuse the non-occurrence of that condition unless its occurrence was a material part of the agreed exchange.

Indeed, the requirement that prejudice must result before a failure to perform a contractual condition or to give a required notice will work a forfeiture is commonplace in the law of California. See *People v. Carrera*, 49 Cal.3d 291, 261 Cal.Rptr. 348 (1989) (failure to give notice of testimony in aggravation of a capital murder sentence harmless where defendant was not prejudiced by lack of notice); *Conservatorship of Rand*, 49 Cal.App.4th 835, 57 Cal.Rptr.2d 119 (1996) (failure to give notice of citation to proposed conservatee harmless where no prejudice resulted); *People v. Howard*, 44 Cal.3d 375, 243 Cal.Rptr. 842 (1988) (untimely notice of evidence to be used in penalty phase of capital murder prosecution harmless where no prejudice shown); *In Re David C.*, 152 Cal.App.3d 1189, 20 Cal.Rptr. 115 (1984) (failure to give adequate notice of termination of custody of minor child harmless where no prejudice shown); *Industrial Asphalt v. Garrett Corp.*, 180 Cal.App.3d 1001, 226 Cal.Rptr. 17 (1986) (failure to serve statutory notice of mechanic's lien claim effective to defeat lien where no prejudice resulted).

Indeed, if anything, notice-prejudice is merely a subspecies of the broader doctrine of harmless error: in every manner of case and circumstance, excepting only jurisdictional delays, courts disregard irregularities and informalities which do not result in substantial prejudice. Thus, the failure timely to post jury fees is regularly excused where no prejudice is proven. *Johnson-Stovall v.*

Superior Court, 17 Cal.App.4th 808, 21 Cal.Rptr.2d 494 (1993). Failure to give proper and advisable jury instructions concerning criminal negligence is ignored where the failure to do so would not have prejudiced the defendant given a jury finding of guilt of first degree pre-meditated and deliberate murder. *People v. Mayfield*, 14 Cal.4th 668, 60 Cal.Rptr.2d 1 (1997). The failure to make timely service of a civil action has likewise been excused absent a finding of prejudice. *Putman v. Clague*, 3 Cal.App.4th 542, 5 Cal.Rptr.2d 25 (1992). Likewise, informalities in the proof of service of documents is ineffective where actual service occurred and no prejudice resulted. *Lum v. Mission Inn Foundation, Inc.*, 180 Cal.App.3d 967, 226 Cal.Rptr. 22 (1986).

This Court, too, has applied the notice-prejudice rule, and in contexts far removed from the insurance industry. *Pioneer Investment Services v. Brunswick Associates Ltd. Partnership*, 507 U.S. 380, 123 L.Ed.2d 74, 113 S.Ct. 1489 (1993) (tardy filing of bankruptcy proofs of claim excused where debtor was not prejudiced by delay). See also *Jersey Shore State Bank v. U.S.*, 479 U.S. 442, 107 S.Ct. 782, 93 L.Ed.2d 800 (1986) (third party lender not unfairly prejudiced by government failure to give notice of tax claim).

In *Cisneros*, the only authority cited by the Ninth Circuit for the conclusion that the notice-prejudice rule is directed specifically at the insurance industry and is applicable only to insurance contracts is *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). *Dedeaux*, of course, only sets forth the standard that to be regarded as a law which regulates insurance, a law must not only have an impact on the insurance industry but must be specifically

directed toward that industry. The Ninth Circuit failed, however, to pursue the analysis of *Dedeaux* into the history of the doctrine in question, which was in *Dedeaux* the availability of punitive damages under Mississippi law. In that analysis, the Court concluded that:

> Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law. 481 U.S. 41 at 50.

The same is true here. The doctrine of excuse of minor breach, termed the notice-prejudice rule, has in some cases been identified with the insurance industry and applied to it in some cases. But the Ninth Circuit did not attempt, nor could it, to show that the common law doctrine to excuse minor, non-prejudicial contract breaches is one specifically directed toward that industry.

It is true that cases applying the notice-prejudice doctrine to the insurance industry may be found and are cited in the Ninth Circuit opinion in *Cisneros* (*Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal.App.4th 715, 15 Cal.Rptr.2d 815, 845 (1993); and *Clemmer v. Hartford Ins. Co.*, 22 Cal.3d 865, 151 Cal.Rptr. 285, 587 P.2d 1098, 1106-1107 (1978)). But citing instances where a rule of general applicability has been applied to a given industry does not make that rule specifically directed at that

industry any more than the application of punitive damage concepts to an insurer in Mississippi made the punitive damage law of Mississippi one directed specifically at the insurance industry.

II. The Issue Presented is of Substantial Significance

The Ninth Circuit decision will result in disparate state by state rulings on topics far beyond notice-prejudice. Any common law doctrine applied to the insurance industry may become the subject of the same Ninth Circuit analysis or lack thereof. The inevitable result will be the "patchwork scheme of regulation" which ERISA's broad preemption provision was enacted to eliminate. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987). Instead of attaining the manifest goal of increased efficiency and reduced costs, plans and plan administrators will be required to pay late claims and, more importantly, to administer plans separately according to the law of each state. This will in turn reduce the affordability of benefit plans and increase the likelihood that benefits will be withdrawn or not offered at all.

CONCLUSION

In enacting ERISA, Congress intended to encourage the provision of benefits in a cost-effective and efficient manner. Granting the petition and reversing the Ninth Circuit's decision will advance the goals of Congress by maintaining the efficiency of nation-wide standards for plan administration and the preservation of the availability of plan benefits for plan beneficiaries.

Respectfully submitted,

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July 20, 1998

No. 97-1868

In The Supreme Court of the United States

October Term, 1998

UNUM Life Insurance Company of America,
Petitioner,

v.

John E. Ward,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

JOINT APPENDIX

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NOTICE

The following items have been omitted in printing this appendix because they appear on the following pages of the printed appendix to the petition for certiorari. They are incorporated herein by reference:

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Order of the District Court granting Summary Judgment, filed August 8, 1995	27a
Declaration of John A. Houser, III and Portions of Exhibits in Support of Motion for Summary Judgment, filed June 26, 1995	34a
Exhibit Portions (MacQuarrie and Ward Deposition Excerpts) to Declaration of Jeffrey P. Smith, filed June 26, 1995	73a
District Court Complaint, filed September 19, 1994	77a

U.S. DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORIA
(San Diego)

Civil Docket for Case #: 94-CV-1454

JOHN E. WARD,
Plaintiff

v.

MANAGEMENT ANALYSIS CO.,
Employee Disability Benefit Plan,
Defendant

DOCKET ENTRIES

Date	No.	PROCEEDINGS
9/19/94	1	Complaint to recover benefits filed t/w exhibits; Summons(es) issued to atty on 9/27/94; (referred to Magistrate Anthory J. Battaglia); Receipt No/Amt of Fee: 7530/$120.00 (bk) [Entry date 09/27/94] [Edit date 09/27/94]
9/27/94	—	Summons issued to atty as to dft Management Analysis Company Employee Disability Benefit Plan (bk)
10/14/94	2	Return of Service re: Summons and Complaint executed upon defendant Management Analysis on 10/7/94 (bk) [Entry date 10/18/94]
10/31/94	3	Stipulation and Order by Judge Marilyn L. Huff; to Answer, to move or otherwise plead to Complaint: due 11/28/94 for Management Analysis (cc: all counsel) (bk) [Entry date 11/04/94]
11/23/94	4	Answer to Complaint by defendant Management Analysis Company Plan (proper party name: UNUM Life Insurance Company of America) (bk) [Entry date 12/08/94]

Date	No.	PROCEEDINGS
11/30/95	5	Order by Magistrate Anthory J. Battaglia; E.N.E. Conference set for 10:00 1/30/95 (cc: all counsel) (bk) [Entry date 12/08/94]
1/30/95	6	Minutes: Enter Order by Magistrate Anthony J. Battaglia; E.N.E. Conference held 10:00 1/30/95; case did not settle; dfts are going to move for summary judgment on timeliness of claim under the contract and as defined by law; Case Management Conference set for 1:30 3/29/95 for scheduling, this date was selected to allow for resolution of the summary judgment motion, which will effect the future scheduling (cc: all counsel) (bk) [Entry date 02/10/95]
3/9/95	7	Minutes: Enter Order by Magistrate Anthony J. Battaglia; Since the Court is issuing a Scheduling Order in this case, the Case Management Conference set for 1:30 3/29/95 is vacated cc: all counsel) (bk) [Entry date 03/22/95]
3/9/95	8	Order by Judge Marilyn L. Huff; Pretrial conf set 10:30 9/5/95; Trial set for 9:00 9/12/95 (cc: all counsel) (bk) [Entry date 03/24/95]
3/10/95	9	Order by Magistrate Anthony J. Battaglia; Discovery by 6/23/95; Settlement Conf 7/27/95 at 1:30; Pretrial orders by 7/27/95; Pretrial Conf set for 9/5/95 at 10:30; Trial set for 9/12/95 at 9:00 (cc: all counsel) (bk) [Entry date 03/24/95]
3/29/95	10	Stipulation and Order by Judge Marilyn L. Huff that dtfs UNUM Life Insurance Co of America and Management Analysis Co Employee Disability Benefit Plan have up to and including 3/28/95 to serve their responses to Pltf's First Req for Prod of Docs; dfts shall

Date	No.	PROCEEDINGS
		not file and serve their anticipated motion for sum jum until after the date of service of their responses (bk) [Entry date 04/14/95]
3/31/95	11	Notice of Motion and Motion by defendant Management Analysis for summary judgment [motion(s) referred to Judge Marilyn L. Huff] on 5/8/95 t/w prf svc (hs) [Entry date 04/14/95]
3/31/95	12	Memorandum of points and authorities by defendant Management Analysis in support of motion for summary judgment [11-1] t/w appendix (hs) [Entry date 04/21/95]
3/31/95	13	Declaration John A Houser III by defendant Management Analysis re motion for summary judgment [11-1] t/w exhibits (hs) [Entry date 04/21/95]
3/31/95	14	Separate Statement of material facts by defendant Management Analysis in support of motion for summary judgment [11-1] (hs) [Entry date 04/21/95]
4/24/95	15	Opposition by plaintiff John E Ward to motion for summary judgment [11-1] t/w Exhibit A (bk) [Entry date 04/25/95]
4/24/95	16	Declaration of John E. Ward re motion response [15-1] (bk) [Entry date 04/25/95]
4/24/95	17	Responses/Objections by plaintiff John E Ward to dft's separate statement of material facts [14-1] (bk) [Entry date 04/25/95]
4/24/95	18	Statement of facts by plaintiff John E Ward in support of opposition to motion for summary judgment [15-1] (bk) [Entry date 04/25/95]
4/24/95	19	Notice of lodgment by plaintiff John E Ward of Exhibit 1—Certified copy of depo tran-

Date	No.	PROCEEDINGS
		script of Dexana MacQuarrie; and Exhibit 2 —Certified copy of depo transcript of Maria E. Bonney in support of Pltf's opposition to motion for summary judgment [11-1] (Exhibits 1 & 2 to Court) (bk) [Entry date 04/25/95]
5/1/95	20	Reply by defendant Management Analysis and Unum Life Insurance Company to opposition to motion for summary judgment [11-1] (bk) [Entry date 05/12/95]
5/1/95	21	Objections by defendant Management Analysis and Unum Life Insurance Co to Pltf's request for summary adjudication (bk) [Entry date 05/12/95]
5/8/95	22	Minutes: Enter Order by Judge Marilyn L. Huff that the motion for summary judgment [11-1] is submitted on the papers—off calendar; Court Reporter: Nancy Cablay (bk) [Entry date 05/24/95]
5/8/95	23	Order by Judge Marilyn L. Huff denying motion for summary judgment without prejudice [11-1] (cc: all counsel) (bk) [Entry date 05/24/95]
6/5/95	24	Order by Judge Marilyn L. Huff denying dft's motion for modified scheduling order (cc: all counsel) (bk) [Entry date 06/25/95]
6/7/95	25	Stipulation and Order by Judge Marilyn L. Huff extending discovery cut-off from 6/23/95 to 8/15/95 for experts only (cc: all counsel) (bk) [Entry date 06/25/95]
6/22/95	26	Notice of Motion and Motion by defendant Management Analysis to strike Pltf's demand for jury trial hearing set for 7/24/95 at 10:30; [motion referred to Judge Marilyn L. Huff] (bk) [Entry date 07/06/95]

Date	No.	PROCEEDINGS
6/22/95	27	Memorandum of points and authorities by defendant Management Analysis in support of motion to strike Pltf's demand for jury trial [26-1] (bk) [Entry date 07/06/95]
6/26/95	28	Notice of Motion and Motion by defendant Management Analysis for summary judgment hearing set for 7/24/95 at 10:30; [motion(s) referred to Judge Marilyn L. Huff] (bk) [Entry date 07/06/95]
6/26/95	29	Memorandum of points and authorities by defendant Management Analysis in support of motion for summary judgment [28-1] (bk) [Entry date 07/06/95]
6/26/95	30	Declaration of John A. Houser III, by defendant Management Analysis re motion for summary judgment [28-1] t/w Exhibits 1-28 (bk) [Entry date 07/06/95]
6/26/95	31	Declaration of Dexana MacQuarrie by defendant Management Analysis re motion for summary judgment [28-1] (bk) [Entry date 07/06/95]
6/26/95	32	Declaration of Maria E. Bonney by defendant Management Analysis re motion for summary judgment [28-1] (bk) [Entry date 07/06/95]
6/26/95	33	Declaration of Jeffrey P. Smith by defendant Management Analysis re motion for summary judgment [28-1] t/w Exhibits 1-3 (bk) [Entry date 07/06/95]
6/26/95	34	Statement of facts by defendant Management Analysis in support of motion for summary judgment [28-1] (bk) [Entry date 07/06/95]
7/10/95	35	Opposition by plaintiff John E Ward to motion for summary judgment [28-1] (bk) [Entry date 07/17/95]

Date	No.	PROCEEDINGS
7/10/95	36	Opposition by plaintiff John E Ward to motion to strike Pltf's demand for jury trial [26-1] (bk) [Entry date 07/17/95]
7/10/95	37	Statement of material facts by plaintiff John E Ward (bk) [Entry date 07/17/95]
7/10/95	38	Opposition by plaintiff John E Ward to dft's separate statement of facts (bk) [Entry date 07/17/95]
7/10/95	39	Declaration of Brooks Iler by plaintiff John E Ward (bk) [Entry date 07/17/95]
7/17/95	40	Reply by defendant Management Analysis to opposition to motion to strike Pltf's demand for jury trial [26-1] (bk) [Entry date 07/21/95]
7/17/95	41	Reply by defendant Management Analysis to opposition to motion for summary judgment [28-1] t/w Exhibits A-C (bk) [Entry date 07/21/95] [Edit date 07/21/95]
7/19/95	42	Minutes: Enter Order by Magistrate Anthony J. Battaglia; Mandatory Settlement conference set for 7/27/95 is reset to 1:30 8/3/95; Mr. Iler is ordered to notice all counsel of change (cc: all counsel) (bk) [Entry date 08/01/95]
7/24/95	43	Minutes: Enter Order by Magistrate Anthony J. Battaglia; per info that Judge Huff has moved the Motion for Sum Jdgm to 8/7/95, Mandatory Settlement conference set for 8/3/95 before Magistrate Judge Battaglia is contd to 1:30 9/8/95 (cc: all counsel) (bk) [Entry date 08/01/95]
7/24/95	44	Minutes: Enter Order by Judge Marilyn L. Huff setting motion for summary judgment [11-1] at 10:30 8/7/95 setting motion for

Date	No.	PROCEEDINGS
		summary judgment [28-1] at 10:30 8/7/95 setting motion to strike Pltf's demand for jury trial [26-1] at 10:30 8/7/95; court requests further briefing; Court Reporter: Nancy Cablay (bk) [Entry date 08/01/95]
7/27/95	45	Supplemental Brief by plaintiff John E Ward re: date of disability in opposition to motion for summary judgment (bk) [Entry date 08/07/95]
7/27/95	46	Supplemental Declaration of plaintiff John E Ward re brief [45-1] (bk) [Entry date 08/07/95]
7/31/95	49	Supplemental Brief filed by defendant Management Analysis t/w Ex. A-B (bk) [Entry date 08/10/95]
8/2/95	47	Reply by plaintiff John E Ward to supplemental brief in opposition to motion for summary judgment [28-1] (bk) [Entry date 08/07/95] –
8/3/95	48	Minutes: Enter Order by Judge Marilyn L. Huff that the motion for summary judgment [11-1] is submitted; that the motion for summary judgment [28-1] is submitted; that the motion to strike Pltf's demand for jury trial [26-1] is submitted; Court Reporter: Nancy Cablay (bk) [Entry date 08/07/95]
8/8/95	50	Order by Judge Marilyn L. Huff granting motion for summary judgment [28-1] (cc: all counsel) (bk) [Entry date 08/15/95]
8/14/95	52	Minutes: Enter Order by Magistrate Anthony J. Battaglia; due to conflict on court's calendar; Mandatory Settlement conference set for 1:30 9/8/95 is reset to 2:00 9/8/95 (cc: all counsel) (bk) [Entry date 08/18/95]

Date	No.	PROCEEDINGS
8/17/95	51	Clerks Judgment: Defendant's Motion for Summary Judgment granted terminating case (cc: all counsel) (bk)
8/22/95	53	Notice of appeal by pla John E Ward from Dist. Court decision Receipt No/Amt of Fee: #17278/$105, [51-2] (ms) [Entry date 08/24/95]
8/23/95	54	Notice by plaintiff John E Ward of association of attorney Janice R Mazur (bk) [Entry date 08/24/95]
8/28/95	—	Record on Appeal sent to Circuit Court [53-1] (ms)
9/6/95	55	Notification by Circuit Court of Appellate Docket Number [53-1] 95-56269 (ms) [Entry date 09/08/95] [Edit date 01/07/98]
9/12/95	56	Transcript Designation and Ordering Form for dates: 8/3/95 [53-1] (ms)
9/27/95	—	Reporter's Transcript of proceedings for the following date(s): 8/3/95 (Re: [53-1]) (ms) [Entry date 10/03/95]
10/11/95	—	Mailed Certificate of Record Transmitted to USCA [53-1] (cc: all counsel) (ms)
1/16/96	57	Notice by plaintiff John E Ward of firm name change, address, telephone number and fax; please be notified that our firm name has changed and our address, telephone number and fax number have changed as follows, Iler and Palkowitz, APC, 4542 Ruffner Street, Suite 300, San Diego, CA 92111; telephone (619) 560-1400; t/w prf of srvc (lmm) [Entry date 01/22/96]
2/28/96	—	Mailed Original Clerk's record on appeal to USCA [53-1] 1 transcript (ms)

Date	No.	PROCEEDINGS
11/18/96	—	Mailed Original Clerk's record on appeal to USCA [53-1] 3 vols (ms)
1/14/97	58	Notice by plaintiff John E Ward of change of address and firm name change; attorney for pla, Brooks L. Iler, 11770 Bernardo Plaza Ct. Suite 205, San Diego, CA 92128, ntc to attny maintenance (jrl) [Entry date 01/21/97]
1/2/98	59	Notice by plaintiff John E Ward of change of firm name ; ILER & ILER, LLP, Attorneys at Law; t/w prf svc; (submitted copy to attorney maintenance clerk) (bar) [Entry date 01/05/98] [Edit date 01/09/98]
3/4/98	60	Order by Magistrate Anthony J. Battaglia ; Status conf set for 3:00 3/31/98 ; Settlement conference set for 3:00 3/31/98; documents shall be produced to defendant by 3/20/98; defendant will review the information by no later than 3/27/98; per order of 3/11/98, this order following settlement status conference was filed in error in the above referenced case and the clerk of the court is hereby directed to strike the order (cc: all counsel) (bar) [Entry date 03/05/98] [Edit date 03/11/98]
3/11/98	61	Order directing clerk of the court to strike order following settlement status conference filed 3/4/98 by Magistrate Anthony J. Battaglia striking Scheduling order ; striking order [60-2]; (cc: all counsel) (bar) [Edit date 03/13/98]
4/3/98	—	Received judgment from USCA. Forward to Court Clerk for calendar. (ms) [Entry date 04/06/98]
4/16/98	62	Notice of Spreading the Mandate; appeal mandate hearing set 10:30 4/27/98 re USCA

Date	No.	PROCEEDINGS
		reversing & remanding the USDC decision (cc: all counsel) " (pa) [Entry date 04/21/98]
4/27/98	63	Hearing requisite to filing the certified copy of the judgment of the USCA reversing and remanding the decision of the USDC STAYED until 10:30am on 7/13/98. Status hearing re: writ of certiorari set for 7/13/98 at 10:30am. (cc: all counsel) " (jp) [Entry date 04/30/98]
4/30/98	64	Order by Judge Marilyn L. Huff; 4/27/98 parties appeared for a hearing with the court Status conf set for 10:30 7/13/98 (cc: all counsel) (bar)
7/13/98	65	Minutes of Mandate Hearing, certified copy of USCA jgm reversing and remanding USDC decision ordered filed and entered; status hrg re writ of certiorari continued to 11/2/98 at 10:30 AM; parties are on notice that if the USDC declines to hear writ of certiorari, the ct will set dates immediately. Court Reporter: N Cablay (pa) [Entry date 07/14/98] [Edit date 07/14/98]
7/13/98	66	Certified copy of judgment from USCA reversing and remanding decision of the District Court re: appeal [53-1] (cc: all counsel) (pa) [Entry date 07/14/98]
7/16/98	67	Order by Judge Marilyn L. Huff: Status conf is set for 10:30 11/3/98 Parties shall contact Court's Clerk to reschedule this status conf in the event the U.S. Supreme Court renders a decision declining to review dft's petition for a writ of certiorari prior to scheduled status conf. (cc: all counsel) (hmr) [Entry date 07/17/98] [Edit date 07/23/98]

Date	No.	PROCEEDINGS
10/19/98	68	Amended Scheduling Order by Judge Marilyn L. Huff: Status conf is scheduled for 10:30 11/2/98 (cc: all counsel) (hmr) [Entry date 10/20/98]
11/2/98	69	Minutes: Enter Order by Judge Marilyn L. Huff ; Status conf re writ of certiorari vacated 10:30 11/2/98; USSC has granted writ of certiorari; (cc: all counsel) Court Reporter: n/a (jrl) [Entry date 11/05/98]

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

No. 95-56269

JOHN E. WARD,
Plaintiff-Appellant

v.

MANAGEMENT ANALYSIS COMPANY EMPLOYEE DISABILITY BENEFIT PLAN, (proper party name)
UNUM Life Insurance Company of America,
Defendant-Appellee

DOCKET ENTRIES

Date	PROCEEDINGS
9/1/95	DOCKETED CAUSE AND ENTERED APPEARANCE OF COUNSEL. CADS SENT (Y/N) : yes. Briefing schedule is as follows: CADS is past due; CADS must be filed no later than 9/8/95; aplt's designation of RT is due 9/1/95; aple's designation of RT is due 9/11/95; aplt shall order transcript by 9/21/95; court reporter shall file transcript in DC by 10/23/95 for Nancy Cablay; certificate of record shall be filed by 10/30/95; aplt's opening brief is due 12/11/95; aple's brief is due 1/10/96; aplt's reply brief is due 1/24/96. [95-56269] (jr) [95-56269]
9/8/95	Filed Janice R. Mazur for Appellant John E. Ward Civil Appeals Docketing Statement served on 9/6/95 (Confatt) [95-56269] [95-56269] (gva) [95-56269]

Date	PROCEEDINGS
9/18/85	Filed Nancy Cablay's notice of order of transcript RT ordered 9/1/95; Expected payment date: 9/5/95. (CASEFILES [95-56269] (hh) [95-56269]
10/11/95	Filed order CONFATT (blsp) This case is under consideration for inclusion in the settlement program . . . Unless otherwise ordered by the court, a settlement assessment conference will be held on 11/14/95 at 4:40 pm PT. The conference will be held by telephone . . . The court will initiate the telephone call . . . The existing briefing schedule remains in effect. [95-56269] (hh) [95-56269]
10/19/95	Filed certificate of record on appeal RT filed in DC 09/27/95 [aplt Ward by atty Mazur] [95-56269] (cmj) [95-56269]
12/13/95	Filed original and 15 copies Appellant John E. Ward opening brief (Informal: n) 32 pages and five excerpts of record in 2 volumes; served on 12/11/95 [95-56269] (hh) [95-56269]
1/12/96	Filed original and 15 copies appellee Management Analysis' 32 pages brief; served on 1/10/96 [95-56269] (hh) [95-56269]
1/17/96	14 day oral extension by phone of time to file Appellant John E. Ward's reply brief. [95-56269] appellants' reply brief due 2/12/96; (jlc) [95-56269]
1/17/96	Rec'd notice of firm name change, and change of address from Brooks Iler and Janice R. Mazur for Appellant John E. Ward, served on 1/12/96. (CASEFILES) [95-56269] (hh) [95-56269]
2/14/96	Filed original and 15 copies John E. Ward reply brief, (Informal: n) 14 pages; served on 2/12/96 [95-56269] (hh) [95-56269]
2/14/96	Rec'd notice of change of address from Janice R. Mazur for Appellant John E. Ward, served on 02/12/96. (CASEFILES) [95-56269] (hh) [95-56269]

Date	PROCEEDINGS
3/5/96	Filed, as of 10/19/95, certified record on appeal in 1 Vol (total): 1 RT (Orig) (Records) [95-56269] [95-56269] (gva) [95-56269]
3/18/96	Received aples' "Notice of related cases"; served on 3/14/96 (CASEFILES/RECORDS) [95-56269] (hh) [95-56269]
3/20/96	Filed order CONFATT (DLP) The court has determined that this appeal will not be selected for inclusion in the settlement program. All further inquiries regarding this appeal should be directed to the clerk's office. Csl are requested to contact the circuit mediator should circumstances develop that might warrant the initiation of settlement discussions. [95-56269] (hh) [95-56269]
3/23/96	Calendar check performed [95-56269] (aw) [95-56269]
5/2/96	Received Appellant's opposition to motion to consolidate cases; served on 5/1/96 (nan promo - no motion pending to consolidate) (CASEFILES) [95-56269] (hh) [95-56269]
5/8/96	Filed motion & order; (Deputy Clerk: lp) The crt is in recpt of the motion for leave to cons the above-captioned appeals filed by Aple UNUM Life Ins. Co., et al. The motion is granted in part. The following appeals shall be cons only for the purpose oral arg: 95-56179, 95-56269, and 96-55147. Appeal 95-16796 shall not be cons and shall be heard separately in 96-55147, 95-56179, 95-56269 (Motion recvd 04/23/96) [96-55147, 95-56179, 95-56269] (ot) [95-56179 95-56269 96-55147]
5/9/96	Filed Appellee UNUM Life's reply to aplt John E. Ward's opposition to motion to consolidate cases; served on 5/8/96 (work in progress/PROMO) [95-56269] (hh) [95-56269]

Date	PROCEEDINGS
5/28/96	Filed order/promo (Appellate Commissioner) The court is in receipt of aplt John Ward's opposition to the motion to consolidate the above-captioned appeals filed by aple UNUM Life Insurance Co., et al. The court is also in receipt of aple UNUM Life Insurance Company's reply to aplt Ward's opposition. The court construes the motion to be a motion for reconsideration of the court's 5/8/96 clerk order. So construed, the motion is granted in part. These appeals shall be calendared before the same oral argument panel, at the time the earliest eligible appeal is calendared Unless the panel directs otherwise, each appeal shall be treated as an independent appeal and will receive a full allotment of oral argument time. [95-16796, 95-56179, 95-56269, 96-55147] (em) [95-16796 95-56179 95-56269 96-55147]
8/20/96	Calendar check performed [95-16796, 95-56179, 95-56269, 96-55147] (aw) [95-16796 95-56179 95-56269 96-55147]
10/4/96	Filed aple Management Analysis' motion to substitute the law firm of Bannan, Green, Smith, Frank & Rimac, in place and stead of Adams, Duque & Hazeltine; served on 10/3/96 (CASEFILES) [3095836] (hh) [95-56269]
10/23/96	Calendar materials being prepared. [95-16796, 95-56179, 95-56269, 96-55147] [95-16796, 95-56179, 95-56269, 96-55147] (aw) [95-16796 95-56179 95-56269 96-55147]
11/1/96	CALENDARED: Pasadena January 9, 1997 9:00 a.m. Courtroom 1 [9-56269] (mw) [95-56269]
11/12/96	Filed supplement to certified record on appeal (filed) in 3 Volumes 3 Clerk's Rec (sent to Judge) [95-56269] (em) [95-56269]
1/9/97	ARGUED AND SUBMITTED TO Betty B. FLETCHER, Stephen S. TROTT, Bruce S. Jenkins [95-56269] (lu) [95-56269]

Date	PROCEEDINGS
1/15/97	Rec'd notice of change of address from Brooks Iler for Appellant John E. Ward in 95-56269 dated 1/11/97. [95-56269] (em) [95-56269]
2/13/97	Rec'd notice of change of address from Janice R. Mazur for Appellant John E. Ward in 95-56269 dated 2/9/97. [95-56269] (em) [95-56269]
2/3/98	FILED OPINION: REVERSED & REMANDED (Termniated on the Merits after Oral Hearing; Reversed; Written, Signed, Published. Betty B. FLETCHER; Stephen S. TROTT; Bruce S. Jenkins, author.) FILED AND ENTERED JUDGMENT. [95-56269] (tsp) [95-56269]
2/12/98	Filed motion and deputy clerk order ; (Deputy Clerk: EM) granting aples' motion & order to extend time to file a petition for rehearing [3393590-1] petition for rehearing due 2/24/98. (Motion recvd 2/12/98) [95-56269] (em) [95-56269]
2/25/98	[3401963] Filed original and 40 copies Appellee Management Analysis and Unum Life Insurance in 95-56269 petition for rehearing with suggestion for rehearing en banc 22 p.pages, served on 2/24/98 PANEL AND ACTIVE JUDGES [95-56269] (em) [95-56269]
3/23/98	Filed order (Betty B. FLETCHER, Stephen S. TROTT, Bruce S. Jenkins,): The petition for rehearing is denied and the suggestion for rehearing en banc is rejected. [95-56269] (em) [95-56269]
3/31/98	MANDATE ISSUED [95-56269] (em) [95-56269]
5/26/98	Received notice from Supreme Court: petition for certiorari filed Supreme Court No. 97-1867 (in 95-56179) ; No. 97-1868 (in 95-56269) ; filed on 5/21/98. [95-56179, 95-56269] (em) [95-56179 95-56269]

Date	PROCEEDINGS
10/16/98	Filed Supreme Court order (SC Date: 10/13/98). re: The motion of Standard Insurance Company for leave to file a brief as amicus curiae is GRANTED. The motion of Association of California Life and Health Ins. Companies for leave to file a brief as amicus curiae is GRANTED. The motion of American Council of Life Insurance, et al., for leave to file a brief as amicus curiae is GRANTED. The petition for a writ of certiorari is GRANTED. (PANEL) [95-56269] (sm) [95-56269]
10/16/98	Received notice from Supreme Court, petition for certiorari GRANTED on 10/13/98. Supreme Court No. 97-1868 (PANEL) (sm) [95-56269]

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

Case No. 94-1454H (AJB)

JOHN E. WARD,
Plaintiff,

v.

MANAGEMENT ANALYSIS COMPANY
EMPLOYEE DISABILITY BENEFIT PLAN,
Defendant.

DECLARATION OF JOHN E. WARD

April 29, 1995

I, John E. Ward, declare as follows:

1. I am plaintiff in this action. The following facts are personally known to me and if called upon to do so, I could and would competently testify thereto.

2. I became employed at Management Analysis Company ("MAC") in 1983 as Vice President of the general management consulting department. At the time I left my employment with MAC in May 1992 I was the President and CEO of the company.

3. I suffer from diabetic neuropathy which began with nerve damage to my feet in 1986 and has, since that time extended to my legs and eyes, rendering me totally and permanently disabled.

4. In August or September 1992 I had a telephone conversation with Marie Bonney, the employment administrator in MAC's human resources department, and advised her that I was disabled and inquired about the impact

of disabiilty on my health insurance coverage under COBRA.

5. In October 1992 I consulted with Dr. Robert A. Smith regarding the pain and marked weakness in my legs. Thereafter I underwent a series of medical consultations with other physicians which continued over the next few months.

6. In February 1993 I submitted my application for state disability to the State of California.

7. The State of California granted my disability application in late February or early March 1993. I thereupon contacted Dexana MacQuarrie, the vice president of administration at MAC, and discussed with her the fact that I was totally disabled and had received acknowledgement of my disability from the State of California. I inquired about benefits and she advised me regarding my rights under COBRA to extend my health insurance in light of my permanent disability.

8. On or about March 30, 1993 I received a letter from Ms. MacQuarrie acknowledging my permanent disability and discussing my rights and benefit under COBRA as a result of my disability and explaining that, in order to extend my health care benefits, I would need a determination of disability from the Social Security Administration.

9. In July 1993 I received my social security award of disability. I forwarded it to Maria Bonney who then assisted me in extending my health insurance benefits under COBRA.

* * * *

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

[Caption Omitted in Printing]

SUPPLEMENTAL DECLARATION OF JOHN WARD

July 27, 1995

I, John Ward, declare as follows:

1. I am plaintiff in this action. The following facts are personally known to me and if called upon to do so, I could and would competently testify thereto.

2. I have suffered from diabetic neuropathy since the mid-eighties. The symptoms which I experienced from that time until early 1992, primarily numbness and tingling, affected my work only minimally.

* * * *

7. During the last week I worked at MAC, and the following week, commencing May 11, 1992, when I was present at MAC cleaning out my office and otherwise "winding up", my condition was sufficiently severe as to require me to use a cane to get around.

8. Despite having been unexpectedly removed from my position, I fully expected to return to work, either as a part-time independent consultant for MAC, or in some other capacity with another company. In fact, during the next several months, I negotiated a new severance agreement with MAC and an independent contractor agreement that specifically provided for me to perform consulting services for MAC. Unfortunately, as it turned out, my health never improved and I was not physically able to perform consulting assignments.

9. During the next few months, my condition did not improve, as I had expected it would; instead, it became

worse. During the summer or early fall of 1992 I experienced increased pain and weakness in my legs, particularly the right leg, and thereafter began experiencing more severe low back pain. In approximately early October 1992 a marked increase in pain and weakness coupled with a reduced ability to negotiate steps or inclines and the fact that the condition had lasted much longer than it had in the past prompted me to consult with Dr. Robert Smith, who then referred me to a number of other physicians for evaluation. Ultimately, by December of 1992, I believed that I was permanently disabled.

10. In August or September of 1992 I advised MAC benefits administrator Maria Bonney in a telephone conversation that I was disabled and inquired at that time as to certain available benefits in light of the disability.

11. In July 1993, I submitted to MAC my formal written social security award of disability, which was issued in July 1993, but which acknowledged a disability date of May 10, 1992.

I declare under penalty of perjury under the laws of the United States that the foregoing is true and correct. Executed this 27th day of July, 1995 in San Diego, California.

/s/ John E. Ward
JOHN E. WARD

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

[Caption Omitted in Printing]

DEPOSITION OF DEXANA MACQUARRIE

* * * *

[22] Q. Did it list an effective date of disability?

A. It listed the date of his—I believe his termination, or maybe it was the end of the month of his termination. I believe his coverage was through May of '92. It listed that as the appropriate date.

Q. Did you consider at that time advising Mr. Ward that he may be entitled to LTD benefits?

A. No.

Q. Do you know why?

A. It never occurred to me that—the subject of LTD never crossed my mind. My only involvement with him was on the extension of the COBRA, and that was the single focus of our interface.

* * * *

Deposition Exhibit MacQuarrie 1

FMAC
MANAGEMENT ANALYSIS COMPANY

March 30, 1993

John E. Ward
4721 Sara Drive
Torrance, CA 90503

Dear John:

I was disappointed to hear that your condition is not improving and is now considered a permanent disability. In response to your request for continuation of your COBRA coverage, I want to advise you of the requirements under our plan which is governed by the federal laws established for COBRA.

The Plan Document (copy of portion which references continuation coverage attached) and the portion of the Summary Plan Description related to this issue (copy also attached for reference) do not set forth all specifics related to continuation coverage. While these documents confirm that continuation coverage will ~~never exceed~~ 36 months, the provision for extending coverage for disabled benefits is limited to 29 months (see attached excerpt from a document published by the Bureau of National Affairs in Washington, D.C.).

When you terminate employment, you are entitled to extend insurance coverage through COBRA for an additional 18 months. Since you terminated with MAC mid-month on May 8, 1992, your regular health coverage did not terminate until May 31 and your COBRA benefits began June 1. Accordingly, MAC's obligation to pay for your COBRA coverage for twelve months ends effective May 31, 1993. At that time you have the option to continue

paying the COBRA premium ($495/month for medical, dental and prescription and $455/month for medical and prescription only for calendar 1993) for an additional six months of coverage through November 30, 1993.

After that time, as shown on the attached excerpt, you are entitled to continue COBRA for an additional 11 months if:

- You obtain a determination from the Social Security Administration of disability at the time of the qualifying event (i.e., June 1, 1992, when you were no longer eligible for insurance under MAC's health plan and became a COBRA participant).
- Notify MAC of the above determination before the end of the 18 months coverage period (i.e., November 30, 1993) and within 60 days after the date of determination of your disability by the Social Security Administration.

Upon receipt of the proper documentation we can continue your COBRA benefits through October 31, 1994. The premium for this additional 11 months coverage will be 150% of the 1994 COBRA rate, as allowed by federal law and consistent with corporate practice for additional extensions of COBRA for participants requesting coverage based on a disability.

John, please feel free to call me if I can do anything to assist you. I'll be happy to help you in any way I can.

Personal regards,

/s/ Dexana G. MacQuarrie
DEXANA G. MACQUARRIE
Vice President

cc: J. Dollard

UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF CALIFORNIA

[Caption Omitted in Printing]

DEPOSITION OF MARIA E. BONNEY

* * * * *

[14] Q. And again, as far as you know, that was done on a monthly basis?

A. Yes.

Q. As you sit here today, have you ever personally submitted a disability claim for a member or assisted a member in submitting a disability claim?

A. Yes.

Q. Approximately, how many?

A. Five.

Q. Do you remember when you first assisted someone?

A. Had to be, oh, probably, three or four years ago. Four years ago.

Q. Do you remember the circumstances just generally of how that occurred, the nature of the disability?

A. Employee had had a stroke, and his wife called to find out what benefits were available and medicalwise and everything because he wasn't able to talk or write or anything. So she called.

Q. Did she call and specifically ask for a disability claim form, or was it the type of thing she just wanted to know what benefits she was entitled to, and then you suggested what benefits she may be entitled to?

A. I don't remember the exact conversation, but I I would think that I would get his file, look, see what he had, walk through what he had, and just go through it with her.

[15] Q. Just from a procedural standpoint, do you recall how that disability claim was handled? In other

words, did you provide the application, or did she have to go to UNUM for the application? How did that work?

A. I believe in this case, we provided her the application. Since we had some on file, I sent it to her.

Q. And then was the application returned to you or directly to UNUM?

A. In this case it was returned directly to me, and I sent it into UNUM for her.

Q. Did you have any additional involvement in the disability claim for that individual?

A. No.

Q. Was he put on long-term disability?

A. Yes.

Q. Can you remember any of the other people who applied for disability through your office?

A. Yes.

Q. Describe for me the nature of the disability, and again, we'll go through the procedure that was followed then.

A. Okay. There was an instance where a lady was pregnant with twins and her doctor put her on bed rest for five months, and so she had called, wanted to know, again, what benefits were available, since she couldn't work, and she then requested an application for LTD, and I sent it to her, and then she submitted it to UNUM.

Q. Do you remember any of the others?

[16] A. There was another one, a gentleman that had knee surgery, and he was unable to work for a while, and again, he requested an application. I sent it to him, and he submitted it directly to UNUM.

Q. I think there were two others, if you remember them.

A. One other—he had throat cancer, and I honestly don't remember sending him the application. I believe he got it directly from UNUM. I remember talking to him about it, and he had some questions about what he has to do, and I believe he got it directly from UNUM. I had very little involvement with that one.

Q. Do you remember the nature of the questions that he had regarding the application?

A. It was more the time frame, what the benefits were, you know. They were kind of minimal, but I just remember he had a few questions.

Q. And the last one, if you remember. Wait a minute. No. There should be one more.

A. The only way I can think of what it is, if I look at the file and see what the file says. Maybe there was only four.

Q. Do you remember the last time you handled a disability claim? By handled I mean participated in the process.

A. It was the one with the throat cancer. It was the most recent.

* * * *

[21] Q. Prior to him sending that to you, had you had any conversation with him where he advised you that he thought he was disabled?

A. No.

Q. Are you saying that you first became aware that he was disabled when you received the Social Security disability information?

A. Yes.

Q. And prior to that time, you had no conversation with him regarding his disability status?

A. I did not talk with him, no.

Q. Was it after that time that you received the Social Security information that you had conversations with him regarding the COBRA extension?

A. I never talked to him about the COBRA extension.

Q. Okay.

A. He did call me. When he got his Social Security document, I remember him calling me and saying it's in the mail, and you should receive it the next day.

Q. Was there any discussion at that time regarding his potential entitlement to long-term disability benefits?

A. No.

Q. Did you believe at that time that he was eligible for long-term disability benefits?

A. I never even thought about it.

(8)

No. 97-1868

Supreme Court, U.S.
FILED
DEC 2 1998
CLERK

IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF FOR PETITIONER

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QUESTIONS PRESENTED

1. Whether, in an opinion expressly acknowledging a circuit conflict—indeed, one affecting eight circuits—the Ninth Circuit erred in holding that a state law (the "notice-prejudice" rule) need not satisfy all three McCarran-Ferguson Act criteria for the "business of insurance" in order to be saved from preemption under ERISA.

2. Whether the Ninth Circuit—contrary to the law in nine other circuits—erred in holding that a state law survives ERISA preemption even though it conflicts not only with ERISA's requirement that fiduciaries administer all plans "in accordance with" their written terms, but also with ERISA's exclusive civil enforcement scheme by expanding the remedies beyond those expressly provided for in the Act.

3. Whether—also contrary to the law in other circuits—the Ninth Circuit erred in holding that ERISA does not preempt a state law (one incorporating agency principles) even though it conflicts not only with ERISA's regulation of initial claims filing and processing and its allocation of fiduciary responsibility, but also with the remedies provided in its exclusive civil enforcement scheme.

PARTIES

The petitioner is UNUM Life Insurance Company of America ("UNUM"). The respondent is John E. Ward.

Pursuant to Rule 29.6 of the Rules of the Supreme Court, petitioner states that UNUM Corporation is the parent of UNUM. UNUM Corporation has two non-wholly owned subsidiaries, Boston Compania Argentina de Seguros S.A. and UNUM Delaware Company. UNUM Life Insurance Company of America has one non-wholly owned subsidiary, SP Administrator, LLC.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

No. 97-1868

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF FOR PETITIONER

OPINIONS BELOW

The opinion of the Court of Appeals is reported at 135 F.3d 1276 (9th Cir. 1998), and is reprinted in the Appendix to the Petition for Writ of Certiorari ("Pet. App.") at 1a-25a. The District Court opinion granting summary judgment to the Management Analysis Company Employee Disability Benefit Plan and UNUM (Pet. App. 2a and 27a-33a) is unreported.

JURISDICTION

The Court of Appeals' order denying UNUM's petition for rehearing, with a suggestion for rehearing en banc, was entered on March 23, 1998. Pet. App. at 26a. Petitioner filed a timely Petition for a Writ of Certiorari on May 20, 1998, and the petition was granted by Order of

this Court dated October 13, 1998. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTES AND REGULATIONS INVOLVED

This case involves the federal statutes and regulations set forth in the Appendix to the Petition for a Writ of Certiorari at 99a-108a.

STATEMENT OF THE CASE

A. Factual Background

In February of 1983, UNUM Life Insurance Company of America ("UNUM") issued a group long-term disability insurance policy to fund an employee welfare benefit plan (the "Plan") sponsored by Management Analysis Company ("MAC"), an employer with multi-state operations. Pet. App. at 59a, 47a. Respondent John Ward worked for MAC in California, serving as its President and Chief Executive Officer ("CEO"). Pet. App. at 2a, 78a, 83a-86a. The Plan is covered by the Employee Retirement Income Security Act of 1974 ("ERISA"), as amended, 29 U.S.C. § 1001, *et seq.* Pet. App. at 2a. In establishing the Plan, the employer was the Plan Sponsor and chose to serve as Plan Administrator.[1] As allowed by ERISA § 3(1), the employer funded the Plan by purchasing a group disability policy from UNUM and delegated to UNUM the responsibility for administering benefit claims and conducting the ERISA fiduciary review procedure for denied claims required by § 503. 29 U.S.C. §§ 1002(1), 1133. Pet. App. at 39a. The Plan expressly provided that the employer served as Plan Administrator and acted on its own behalf or as an agent for its employees, and not as UNUM's agent. Pet. App. at 44a.

A participant in the Plan since its inception in 1983, Ward admitted that he was aware of the Plan and had

[1] Pet. App. at 13a; ERISA § 3(16)(A), (B), 29 U.S.C. § 1002(16)(A), (B).

received from MAC in 1983 a certificate of coverage containing the Plan's summary plan description. Pet. App. at 2a. This certificate described the Plan's benefits and requirements for eligibility and participation, as well as the procedures and deadlines Ward must follow in submitting claims to UNUM. Pet. App. at 41a-43a. As CEO, Ward met annually with the company's human resources division to review all of MAC's insurance plans, including this Plan. Five months before his resignation in 1992, Ward attended a meeting at which a UNUM representative presented a summary of the Plan's benefits. Pet. App. at 32a-33a.

Ward served as President and CEO of MAC until May 8, 1992, when he resigned upon the Board of Directors' request over financial concerns about a particular company project. Pet. App. at 27a. Ward claims that by December of 1992 he had received a diagnosis of diabetes. In early 1993, he received state disability benefits, and alleges that he contacted MAC's human resources division to discuss extension of his COBRA continuation insurance. In July of 1993, he received a determination that he was eligible for Social Security benefits, a copy of which he sent to the human resources division. Pet. App. at 28a.

Ward, however, did not submit a claim for plan benefits until April, 1994, nearly two years after the onset of his claimed disability. Ward asserted that his disability began on May 5, 1992, while he was still employed by MAC. Coincidentally, this was the same day that the Board of Directors asked Ward to resign. UNUM received Ward's notice and proof of claim form on April 11, 1994. This was UNUM's first actual notice of the claimed disability. Pet. App. at 38a.

The Plan's written notice and proof of claim provisions are unambiguous and lawful under ERISA. Pet.

App. at 5a.[2] They require a participant to submit a written notice of claim for plan benefits to UNUM within 30 days of the date disability starts, if possible, and a written proof of claim, at the latest, one year and 180 days after the onset of disability. Pet. App. at 42a-43a. Ward's notice of claim was untimely by nearly 15 months, and his written proof of claim was submitted nearly five months after the Plan's last deadline. Pet. App. at 5a. Accordingly, no benefits were "due" under the Plan's written terms.

Despite Ward's annual review of MAC's insurance plans, he asserted that he did not know about the "availability" of the Plan until April of 1994, when he claims he discovered his certificate of coverage among papers in his safety deposit box. Pet. App. at 3a. Further, he contended that MAC should be considered the "agent" of UNUM notwithstanding that MAC was the Plan Administrator, and the Plan expressly stated that MAC was not UNUM's agent. Additionally, he contended that MAC purportedly knew he was "disabled" by 1992 or 1993, and that this claimed knowledge should not only be imputed to UNUM but also free him from the Plan's requirements of timely written notice and proof of claim to UNUM. Pet. App. at 96a-98a.

After reviewing Ward's claim for plan benefits and supporting materials, UNUM determined that he was ineligible because he did not submit his written claim within the Plan's written time limits. UNUM notified him of its decision in April of 1994; he, in turn, requested a review. After completing the ERISA-required fiduciary review procedure for denied claims, UNUM upheld the decision to deny plan benefits based on the Plan's written terms. Pet. App. at 96a-98a.

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[2] *See also Cisneros v. UNUM Life Ins. Co. of America*, 134 F.3d 939, 943 (9th Cir. 1998), petition for writ of certiorari filed, Case No. 97-1867.

B. The District Court Proceeding

On September 15, 1995, Ward filed suit against the Plan and UNUM in United States District Court for the Southern District of California to recover plan benefits under ERISA. Pet. App. at 77a-98a. He did not assert a claim against MAC.

On August 8, 1995, the District Court granted the Plan and UNUM summary judgment pursuant to ERISA. Pet. App. at 2a-27a to 33a. It held that the Plan's written proof of claim provision required that proof of claim be filed with UNUM in writing within one year and 180 days after the onset of disability, and that Ward had failed to comply with this provision. Additionally, it rejected Ward's arguments that California's common-law *Elfstrom* rule[3] survived ERISA preemption and governed the payment of plan benefits. Pet. App. at 30a-33a. In that pre-ERISA case, an employer which performed administrative tasks under an insured welfare plan was held to have been the agent of the insurer, and the employer's knowledge was imputed to the insurer. The *Elfstrom* rule, if applicable, would make MAC the "agent" of UNUM, imputing to UNUM any knowledge the employer had of Ward's disability and, in his view, requiring the Plan to pay benefits regardless of the fact that payment was barred by its written terms. Ward appealed.

C. The Ninth Circuit Decision

On appeal of the summary judgment granted to the Plan and UNUM, the Ninth Circuit reversed the District Court's decision on two grounds: California's notice-prejudice rule and the *Elfstrom* rule.

The Ninth Circuit agreed that Ward had failed to satisfy the Plan's unambiguous written proof of claim provision. It then addressed Ward's argument that the

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[3] The rule takes its name from *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503, 505 (1967).

common-law notice-prejudice rule should be applied to require the Plan to pay benefits, and to preclude UNUM, the claims review fiduciary, from upholding the denial unless it could establish "actual prejudice" from the failure to comply with the proof of claim provision. The Ninth Circuit necessarily held that California's notice-prejudice rule fell within the scope of ERISA's preemption clause as a state law which "relates to" an employee benefit plan. Pet. App. at 5a. ERISA § 514(a), 29 U.S.C. § 1144(a). It then held, however, that the rule was preserved by ERISA's insurance saving clause. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). In so doing, it followed its earlier, companion decision in *Cisneros v. UNUM Life Ins. Co. of America*, 134 F.3d 939 (9th Cir. 1998) ("*Cisneros*"), Pet. App. at 5a-6a, petition for writ of certiorari filed, Case No. 97-1867.

In *Cisneros*, the Ninth Circuit had concluded that under *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-50 (1987), ERISA's saving clause applies if the state law clears two hurdles: a common-sense test that the law be "specifically directed" at the insurance industry, and the saving clause requirement that the law must "regulate insurance." 134 F.3d at 944-945. To determine whether the notice-prejudice rule regulates insurance, the *Cisneros* Court analyzed whether the ERISA claims processing procedures that the rule attempts to regulate satisfy the three criteria established by this Court for determining what constitutes the "*business of insurance*" under the McCarran-Ferguson Act, 15 U.S.C. § 1012. *Id.* at 945. Under these criteria, the regulated practice first must have the effect of transferring or spreading the policyholder's risk of loss to the insurer, "an indispensable characteristic of insurance." *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-212 (1979). Second, the practice must be an integral part of the insurance policy relationship between insurer and

insured, such as regulation of the "*substantive content* of insurance contracts." *Metropolitan Life*, 471 U.S. at 742 n.18 (emphasis added). Third, it must be limited to entities within the insurance industry. *Id.* at 743, *Pilot Life*, 481 U.S. at 48-50.

In *Cisneros*, the Ninth Circuit correctly found that the practice of claims processing at which California's notice-prejudice rule is directed did *not* transfer or spread the policyholder's risk of loss to the insurer, and thus failed to satisfy the first McCarran-Ferguson criterion. 134 F.3d at 945-946. It concluded, however, that the notice-prejudice rule was "saved" because it satisfied the last two criteria. *Id.* Expressly acknowledging that its holding conflicted with two Fifth Circuit decisions, *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.), *cert. denied*, 117 S.Ct. 387 (1996), and *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993), it stated: "We recognize that the Fifth Circuit has held that all three of the McCarran-Ferguson factors must be satisfied . . . . We . . . disagree." 134 F.3d at 946.

The Ninth Circuit also acknowledged a direct conflict between the notice-prejudice rule and ERISA, conceding that the rule caused "*a plan's written terms* [*to be*] *altered,*" caused "*complications and extra burdens*" on plan administration, and made the plan "*more difficult to administer.*" Further, it acknowledged that the rule had been adopted in only approximately half the states and, even in those states, the rule "*differ*[*ed*] *markedly.*" 134 F.3d at 945-947 (emphasis added).

The *Ward* Court followed *Cisneros*' holding that the notice-prejudice rule was saved and then held that ERISA did not preempt California's common-law *Elfstrom* rule under which an employer, as administrator of a group insurance plan, is deemed the agent of the insurer and its knowledge is imputed to the insurer. Like the notice-prejudice rule, the *Elfstrom* rule would require the pay-

ment of benefits contrary to the Plan's written terms. The Ninth Circuit nevertheless held that the rule did not "relate to" an ERISA plan within the meaning of § 514(a). It based this extraordinary holding on *Turrill v. Life Ins. Co. of North America*, 753 F.2d 1322 (5th Cir. 1985), a decision *preceding* this Court's 1987 unanimous decision in *Pilot Life, supra*, which held that ERISA preempts a participant's state common-law causes of action based on a failure to pay benefits under an insured ERISA plan. Pet. App. at 16a-20a. The Ninth Circuit inferred that *Turrill*, a 1985 diversity case, supported a holding of no ERISA preemption because the Fifth Circuit had discussed state law agency theory without, as the Ninth Circuit put it, "even hint[ing] that state agency law is somehow preempted by ERISA." Pet. App. at 18a. This is hardly surprising given that prior to *Pilot Life*, the lower courts including the Fifth Circuit uniformly but incorrectly held that ERISA did *not* preempt such claims. *See, e.g., Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311 (5th Cir. 1985), *reversed*, 481 U.S. 41 (1987). The Ninth Circuit relied on this impliedly overruled and discredited Fifth Circuit authority in *Turrill* in adopting state agency law and applying the *Elfstrom* rule.

SUMMARY OF ARGUMENT

At stake in this controversy is the continued supremacy of federal law in the important areas of ERISA fiduciary standards, plan administration and civil enforcement. Congress designed ERISA to encourage the growth and development of a purely voluntary, financially stable system of employee benefit plans, ones with an "increasingly interstate" "operational scope and impact." ERISA § 2(a), (b), 29 U.S.C. § 1001(a), (b). ERISA accomplishes this goal by providing an exclusive, uniform system of *federal* regulation for both self-funded and insured plans, including "standards of conduct, responsibility, and obligation for fiduciaries," and "appropriate remedies, sanctions, and ready access to the Federal courts." *Id.* ERISA

is " 'an enormously complex and detailed statute' that resolved innumerable disputes between powerful competing interests—not all in favor of potential plaintiffs." *Mertens v. Hewitt Associates*, 508 U.S. 248, 251, 262 (1993) (citation omitted).

Among Congress' principal objectives in drafting ERISA was the elimination of the conflicting system of federal, state and local regulation then governing the administration of employee benefit plans. To ensure federal uniformity of law, Congress enacted a broad array of national, uniform fiduciary standards which require that all plans be "established and maintained pursuant to a written instrument," and be administered strictly "in accordance with" the plan's written terms. ERISA §§ 402(a)(1), 404(a)(1)(D), 29 U.S.C. §§ 1102(a)(1), 1104(a)(1)(D). Consistent with this "written plan instrument" rule, Congress enacted exclusive civil enforcement provisions which strictly limit a participant to suits for benefits "due" under the plan's written terms. ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). The "potential for conflict in substantive law" is "*[p]articularly disruptive*" under ERISA. *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 142 (1990) (emphasis added). To secure the preeminence of federal law, Congress added a "clearly expansive" preemption clause in ERISA § 514(a) in order to permit the "*nationally uniform administration*" of all plans, self-funded and insured alike. *National Conf. of Blue Cross-Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645, 655, 657 (1995) (emphasis added) ("*Travelers*").

The Ninth Circuit ignored this background and engaged in an unprecedented reformulation of ERISA preemption standards even after the pronouncements of *Travelers* and *California Div. of Labor Standards Enforcement v. Dillingham Constr.*, 117 S.Ct. 832, 842 (1997) ("*Dillingham*"). By engaging in unprincipled line-drawing, the Ninth Circuit decision threatens to undermine ERISA's carefully-crafted statutory scheme by expanding the saving clause ex-

ception to preemption far beyond the narrowly-drawn parameters established by Congress. ERISA § 514(b)(2)(A). California's notice-prejudice rule fails to satisfy the common-sense test for insurance regulation, and all three of the McCarran-Ferguson Act criteria for regulation of the "business of insurance." First, the rule does not regulate a practice that transfers the risk of loss, "an indispensable characteristic of insurance," *Royal Drug Co.*, 440 U.S. at 211-212, and on that ground alone the rule is outside the saving clause's protection. Second, it only purports to "regulate[] the *administration* of policies, not their substantive terms." *See Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 570 (11th Cir.), *cert. denied*, 513 U.S. 803 (1994) (emphasis added). Third, it derives from general principles of contract law applicable to all California contracts, and thus is not limited to the insurance industry. Furthermore, even if the saving clause somehow were deemed applicable, ERISA would preempt the rule because it conflicts with a number of the Act's key provisions and frustrates its purposes, including the exclusivity of its civil enforcement scheme. *Pilot Life*, 481 U.S. at 51-57; *see John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank*, 510 U.S. 86, 99 n.9 (1993) ("no decision of this Court has applied the savings clause to supersede a provision of ERISA itself").

At the same time that it vastly expands the saving clause, the Ninth Circuit decision contracts the scope of ERISA's preemption clause to a virtual nil. ERISA § 514(a). The Circuit court held that a plan participant's attempt to obtain plan benefits through the use of a state common-law agency rule, such as *Elfstrom*, falls outside of ERISA preemption because, in the court's view, it simply has no "connection with" a plan and does not provide an alternate enforcement mechanism. This astounding holding effectively reads § 514(a) out of ERISA. It creates a new "preemption" standard which will have an extreme impact not only on suits for benefits

but also on the *entire* administration of insured and self-funded plans, exposing each to federal-state conflict and to fifty different sets of state laws.

The Ninth Circuit decision thus generates, in two important respects, a "*direct clash* between state law and the provisions and objectives of ERISA," one where preemption necessarily arises because " 'compliance with both federal and state regulations is a *physical impossibility*.' " *Boggs v Boggs*, 117 S.Ct. 1754, 1762 (1997) (citation omitted) (emphasis added). The Circuit court openly acknowledged the direct conflict between California's notice-prejudice rule and ERISA, stating that the rule made the plan "*more difficult to administer*" and caused "a plan's written terms [to be] *altered*." *Cisneros*, 134 F.3d at 947 (emphasis added). In the same manner, *Elfstrom* requires the payment of benefits by an interstate employer's plan under circumstances where the plan itself and ERISA's statutory scheme would require a claim denial. The practical effect of the decision will be to wholly supplant ERISA's insistence that plan administration center on the "written plan instrument," in direct contravention of Congress' intent to render plan regulation and civil enforcement " '*exclusively a federal concern*.' " *Pilot Life*, 481 U.S. at 45-46 (citation omitted) (emphasis added).

The Ninth Circuit's decision, moreover, will only spur additional litigation as participants across the country strive to pick and choose from a diverse menu of state law theories instead of pursuing their federal rights under ERISA. If one or two judicial revisions of ERISA's text governing fiduciary duties and civil enforcement are appropriate, through artful but erroneous readings of the preemption and saving clauses, plaintiffs and the lower courts will ask, why not twenty? If twenty, why not two hundred? This departure from the predictable, "uniform" structure of federal regulation decreed by ERISA, *Travelers*, 514 U.S. at 656-657, the resulting disturbance in plan administration and the increased litigation and transaction costs will only lead plan sponsors to a reduction or elim-

ination of benefits, *Fort Halifax Packing Co. v. Coyne*, 482 U.S 1, 13 (1987), all in conflict with the "public interest in encouraging the *formation* of employee benefit plans," *Pilot Life*, 481 U.S. at 54 (emphasis added).

Accordingly, the Ninth Circuit decision cannot be squared with ERISA's provisions, structure or purposes. Instead, the decision marks an attempt to return to the pre-ERISA era when plans primarily were governed by fifty different sets of state law rules, and it will produce the divisive results that ERISA proscribes—conflicting plan administration rules across the land. *Boggs v. Boggs*, 117 S.Ct. at 1762. Chaos, increased benefit costs, and a reduction or elimination of benefits are certain to follow, with plan administration for interstate employers once again becoming a Byzantine maze of conflicting federal-state regulations.

Given the "centrality of pension and welfare plans in the national economy," *Boggs v. Boggs*, 117 S.Ct. at 1760, the disruptions caused by the Ninth Circuit decision cannot stand. This Court should reverse the decision below to restore the carefully-crafted balance between state and federal law struck by Congress in ERISA and to reestablish the preeminence of ERISA's statutory scheme for regulating plan administration.

ARGUMENT

THE NINTH CIRCUIT DECISION IS INCOMPATIBLE WITH ERISA'S STATUTORY DESIGN AND PREEMPTION OF STATE LAWS AND, UNLESS REVERSED, WILL SERIOUSLY DISRUPT THE STATUTORY SCHEME.

I. Congress Designed ERISA To Provide Uniform Federal Regulation For The Administration Of All Plans, Self-Funded And Insured Alike.

ERISA was the "product of a decade of congressional study of the nation's private employee benefit system." *Mertens*, 508 U.S. at 251. ERISA plans are not only "affected with a national public interest," § 2(a), but the

appropriate balance between competing federal and state law is of paramount concern to the nation's employee benefit plan system. One of ERISA's purposes is to avoid a "multiplicity of regulation," a " 'conflict in . . . law' " and " 'conflicting directives' " between federal and state regulatory schemes. *Travelers*, 514 U.S. at 656-657 (citation omitted). In its place, Congress fashioned a federal regulatory system which includes a single standard for evaluating fiduciary conduct and a panoply of civil enforcement provisions to secure the interests of participants and beneficiaries. Congress intended to "minimize[] the need for interstate employers to administer their plans differently in each State in which they have employees." *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 105 (1983).

To accomplish this goal, Congress enacted a detailed set of standards and duties to guide ERISA fiduciaries and thus govern the administration of both self-funded and insured ERISA plans. ERISA §§ 401-414, 503, 29 U.S.C. §§ 1101-1114, 1133. Congress designed ERISA to "protect contractually defined benefits." *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. 134, 148 (1985). The "written plan instrument" requirement of ERISA §§ 402 and 404 is the foundation for ERISA's entire statutory framework. This Court has described the "written plan instrument" rule as one of the Act's "core functional requirements." *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 84 (1995). The plan's written document is accordingly the "cornerstone of an ERISA plan." *Hunt v. Hawthorne Associates, Inc.*, 119 F.3d 888, 891 (11th Cir. 1997). This rule mandates that all plans be established and maintained pursuant to a "written instrument," contain amendment procedures and be administered strictly "in accordance with" their written terms to the extent not inconsistent with ERISA. ERISA §§ 402(a)(1), (b)(3), 404(a)(1)(D), 29 U.S.C. §§ 1102(a)(1), (b)(3), 1104(a)(1)(D).[4] In the words

[4] The plan documents, which include the "contract or other instruments under which the plan is established or operated,"

of the key congressional report, "[a] written plan is to be required in order that every employee may, on examining the plan documents, determine exactly what his rights and obligations are under the plan." H.R. Rep. No. 93-1280, p. 297 (1974); *Curtis-Wright,* 514 U.S. at 83; *Hozier v. Midwest Fasteners Inc.*, 908 F.2d 1155, 1163 (3d Cir. 1990). Indeed, it would be a breach of fiduciary duty for an ERISA fiduciary not to follow the plan's written provisions, ERISA § 404, *Eley v. Boeing Co.*, 945 F.2d 276, 279 (9th Cir. 1991), subjecting it to civil suit and removal as a fiduciary, ERISA §§ 502(a)(2), (3), 409(a), 29 U.S.C. §§ 1132(a)(2), (3), 1109(a).

In expanding the scope of the saving clause, the Ninth Circuit subjected the administration of insured employee benefit plans to state common-law rules that would not apply to self-funded plans under an identical set of facts. The Circuit court's unprincipled line-drawing violates ERISA's statutory scheme, and creates powerful incentives for plan sponsors either to cut back or eliminate insured benefits altogether, or to use self-funded plans despite the greater stability and solvency of insured plans. In enacting the saving clause, Congress intended to allow the states to continue to regulate insurance companies in their *risk-spreading activities*—the core element of the "business of insurance"—through enactments such as mandated-benefit statutes. *See, e.g., Metropolitan Life Ins. Co. v Massachusetts*, 471 U.S. 724 (1985). Congress did *not* intend to surrender control to the states over the ERISA plan activities governed by the Act's substantive provisions, including its fiduciary responsibility rules and civil enforcement procedures. *Pilot Life*, 481 U.S. at 45-46.

Nothing in ERISA supports the Ninth Circuit's assumption that Congress drew any distinction between insured

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encompass group insurance policies. 29 U.S.C. § 1102(a)(1), (b)(2); *see e.g., Belasco v. W.K.P. Wilson & Sons, Inc.*, 833 F.2d 277, 280 (11th Cir. 1987); *Roe v. General American Life Ins. Co.*, 712 F.2d 450 (10th Cir. 1983).

and self-funded plans for purposes of the Act's uniform fiduciary standards, plan administration rules or exclusive civil enforcement provisions. To the contrary, ERISA's text and structure establish that its preeminent federal regulatory framework applies equally to insured plans such as the one before this Court in *Pilot Life, supra.* Congress carefully framed ERISA's definition of "employee benefit plan" to encompass *all* plans, whether established "through the purchase of insurance or otherwise." ERISA § 3(1), (2), (3). Further, the Act's fiduciary standards and civil enforcement scheme explicitly provide the exclusive source of regulation in both instances. *See* ERISA §§ 402, 404-406, 409, 502-503. Indeed, Congress had expressed strong concern that *insured* plans, because of the manner in which they were structured, generally had not been subject to the trust law principles it deemed essential to the adequate protection of the interests of plan participants. Accordingly, Congress codified these federal "trust" principles, not only to ensure "*uniformity*," but to ensure that certain "plans, such as insured plans, which do not use the trust form as their mode of funding," would be subject to the same exacting fiduciary standards. H.R. Rep. No. 533, 93d Cong., 1st Sess. 12 (1973), 2 Legislative History of the Employee Retirement Income Security Act at 2359 ("Legislative History") (emphasis added). The statute is replete with references to insurance funding and administration of employee benefits plans, signifying Congress' recognition of the critical role group insurance plays in the employee benefit field. *See, e.g.*, ERISA §§ 102(b), 103(a)(2), 401(b)(2), 29 U.S.C. §§ 1022(b), 1023(a)(2), 1101(b)(2); *see also* 29 C.F.R. § 2560.503-1. ERISA's plain language thus indicates that the Act subjects the administration and claims-processing of *all* plans, including those plans funded or administered by insurance companies or Blue Cross/Blue Shield organizations, to the same pervasive federal regulation.

To underscore the importance of federal control in this area, Congress vested the federal courts with *exclusive*

jurisdiction over suits alleging a breach of fiduciary responsibility. ERISA § 502(e)(1). Congress, moreover, required that all suits for plan benefits, whether filed in federal or state court, be governed by uniform federal law under ERISA, and it included exclusive civil enforcement provisions which limit a participant's suit to benefits "due" under the plan's written terms. ERISA § 502(a)(1)(B). In particular, Congress made the administration of both insured and self-funded plans, including claims-processing by the plan and its ERISA claims review fiduciary, a matter of exclusive federal concern. *Pilot Life*, 481 U.S. at 45-46.

Most importantly, Congress crafted ERISA § 514 as the principal mechanism for implementing its statutory design. ERISA's preemption clause bars all state law intrusion in the areas of fiduciary conduct [5] and employee

[5] The legislative intent to preempt all state regulation of fiduciary conduct is well illustrated by H.R. 2, as reported by the House Committee on Education and Labor on October 2, 1973. It included the following preemption clause:

> It is hereby declared to be the express intent of Congress that, if any provision of this Act which relates to an aspect of fiduciary responsibility applies to a plan, then no State law which relates to the same aspect of fiduciary responsibility shall be applied to such plan.

H.R. 2, 93d Cong., 1st Sess. § 514(c)(1) (1973), 2 Legislative History at 2346. The Conference Committee ultimately broadened the preemption provision out of fear that the existing version, which superseded only state laws relating to the subject matter of ERISA, would not go far enough in foreclosing the possibility of state regulation. As noted by Senator Javits, a chief architect of ERISA, the prior version "raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme." 120 Cong. Rec. 29,942 (1974). To eliminate this possibility, the Conferees settled on a preemption clause which covered not only state laws that fell within ERISA's subject matter, including fiduciary responsibility, but also any law that could directly or indirectly affect the regulation of employee benefit plans.

benefit plan administration. ERISA § 514(a); *Pilot Life*, 481 U.S. at 47-48, 52-57; *Travelers*, 514 U.S. at 657-658, 661. ERISA's preemption clause—called the "crowning achievement of [the] legislation," 120 Cong. Rec. 29,197 (1974) (remarks of Rep. Dent)—most clearly reflected Congress' efforts to eliminate the threat of conflicting or inconsistent local regulation and establish in its stead a comprehensive and pervasive federal regulatory scheme. *Alessi v. Raybestos Manhattan Inc.*, 451 U.S. 504, 523 (1981). In this manner, Congress designed ERISA to enable the plans of interstate employers to operate in a uniform, cost-effective fashion, and " 'to predict the legality of proposed actions without the necessity of reference to varying state laws.' " *Pilot Life*, 481 U.S. at 56 (citation omitted).

This Court has carefully followed ERISA's text, structure and purposes in deciding ERISA preemption issues. ERISA's preemption clause has "unparalleled breadth," *Holland v. Burlington Indus., Inc.*, 772 F.2d 1140, 1147 (4th Cir. 1985), *summarily aff'd sub nom. Brooks v. Burlington Indus., Inc.*, 477 U.S. 901 (1986), and the Act's civil enforcement provisions have their own "pre-emptive" force. *Pilot Life*, 481 U.S. at 54-56; *see* ERISA § 502(a); *Sofo v. Pan-American Life Ins. Co.*, 13 F.3d 239, 241 (7th Cir. 1994).[6] In *Travelers*, this Court explained that "preemption turns on Congress's *intent*," and that "Congress's intent" was to "establish the *regulation*" of both self-funded and insured ERISA plans " 'as *exclusively a federal concern.*' " 514 U.S. at 655-656 (citation omitted) (emphasis added). Accordingly, it reaffirmed that ERISA not only preempts state laws which " '*deal*[] *with the subject matters covered by ERISA*[,] reporting, disclosure, *fiduciary responsibility*, and the like," but its preemption clause "sweep[s]" even "more broadly."

[6] In the area of claims processing, ERISA preemption includes both state common-law claims, *Pilot Life*, 481 U.S. at 54-56, and claims based on state insurance or unfair trade practices statutes, *Kanne v. Connecticut General Life Ins. Co.*, 867 F.2d 489 (9th Cir. 1988) (as amended, 1989), *cert. denied*, 492 U.S. 906 (1989); *Hogan v. Kraft Foods*, 969 F.2d 142 (5th Cir. 1992).

Id. at 661 (emphasis added). Providing clear guidelines, it explained that ERISA preemption also includes state laws which *"mandate*[] employee benefit *structures* or their *administration," "prohibit"* what is "permitted" by federal law, *"preclude uniform administrative practice,"* or provide *"alternate enforcement mechanisms." Id.* (emphasis added). Additionally, ERISA preemption arises where, as here, the state law conflicts with the substantive terms of a federal statute and " 'compliance with both . . . is a *physical impossibility* . . . or . . . state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.' " *Boggs v. Boggs*, 117 S.Ct. at 1762 (citation omitted) (emphasis added). ERISA also preempts state law rules such as notice-prejudice and *Elfstrom* where the plan's "existence" is "a critical factor in establishing liability" under the state law. *Ingersoll-Rand*, 498 U.S. at 139.

Congress' purpose, therefore, was both to allow plan sponsors a broad freedom of employee benefit plan design, *FMC Corp. v. Holliday*, 498 U.S. 52, 59-60 (1990), and to make ERISA "the *exclusive* form of regulation for . . . plans within the areas covered" by the Act, leaving intact only those state laws "which *otherwise* regulate insurance, banking or securities."[7] The incorporation of the insurance saving clause into ERISA § 514 is not inconsistent with the congressional objectives. Congress fully recognized that under ERISA "state laws regulating banking, insurance and securities [would] remain unimpaired," while simultaneously noting that the Act "provides for a uniform source of law for evaluating the fiduciary conduct of *persons acting on behalf of* employee benefit plans."[8] In contrast to its "repeatedly emphasized purpose" to make federal law preeminent in the fiduciary field, there

[7] Explanatory Statement Concerning S. 3589, 116 Cong. Rec. 7284, 7288 (1970) (emphasis added).

[8] *See* Explanatory Statement Concerning S. 3589, 116 Cong. Rec. 7286 (1970); Explanatory Statement Concerning H. 16462, 116 Cong. Rec. 7570 (1970) (emphasis added).

is a "stark absence" in the legislative history of any intention to save common-law rules such as the "notice" rule preserved by the Ninth Circuit. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. at 148. If Congress had intended to exempt insurance company fiduciaries, acting on behalf of employee benefit plans, from the uniform system it established, there certainly would have been some reference to this fact in ERISA's legislative history, which spans over 15 volumes of material. Congress' silence on this subject is even more significant inasmuch as over 80% of the welfare benefit plans in the United States around the time of ERISA's passage were insured and administered by insurance companies.[9] Under these circumstances, Congress simply could not have intended such a dramatic exception to its regulatory scheme without some affirmative indication to that effect. *See NLRB v. Amax Coal Co.*, 453 U.S. 322, 330 (1981).

ERISA also establishes a comprehensive and remedial framework for plan participants with benefit claims disputes. ERISA §§ 503, 502(a)(1)(B) and 29 C.F.R. § 2560.503-1(c)-(g) contain precise provisions governing the filing and processing of ERISA claims, the fiduciary review procedure for denied claims, and the filing of suits for relief when administrative remedies are exhausted. These procedures and civil enforcement provisions apply equally to both self-funded and insured plans, and are the *exclusive* means of redress, carrying their own "pre-

[9] *See Wadsworth v. Whaland*, 562 F.2d 70, 78 (1st Cir. 1977), *cert. denied*, 435 U.S. 980 (1978) (Congress was aware that insurance was the most common source of plan funding). According to Labor Department statistics, 91% of the welfare benefit plans covering fewer than 100 employees and 83% of welfare benefit plans covering 100 or more employees were insured and administered by insurance companies. 4 Health and Population Study Center, Battelle Human Affairs Research Centers, *Employee Welfare Benefit Plans and Plan Sponsors in the Private Nonfarm Sector in the United States, 1978-1979* at 44 (1980).

emptive force" that bars all state law claims. *Pilot Life*, 481 U.S. at 45-46, 52-54. Section 503 requires "*every* employee benefit plan" to comply with benefit claims regulations issued by the Secretary of Labor and to provide a claims review procedure conducted by the "appropriate named fiduciary" (emphasis added). The regulations specify that the plan's claims procedure may provide for the filing of claims with an insurance company, and "a claim is filed when the requirements of a reasonable claim filing procedure . . . have been met." 29 C.F.R. § 2560.503-1(c)-(d). The regulations also state that an insurance company charged with the review of denied claims is the "appropriate named fiduciary under § 503." *See* 29 C.F.R. § 2560.503-1(g)(2). Like all other fiduciaries, ERISA requires the fiduciary under § 503 to administer the plan strictly "in accordance with" its written terms. ERISA § 404(a)(1)(D).

Further, Congress intended that *all* suits under ERISA to recover plan benefits, whether self-funded or insured, should " 'be regarded as arising under the laws of the United States, in similar fashion to those brought under section 301 of the Labor Management Relations Act,' " which has its own "pre-emptive force." *Pilot Life*, 481 U.S. at 56 (citation omitted). ERISA's goal, accordingly, was that the courts would develop "a body of *Federal substantive law* . . . to deal with issues involving rights and obligations under private welfare and pension plans." 120 Cong. Rec. 29,942 (1974) (remarks of Sen. Javits) (emphasis added). Congress' objective was that "*all* suits brought by . . . participants asserting improper processing of claims . . . by treated as *federal* questions governed by § 502(a)." *Pilot Life*, 481 U.S. at 54 (emphasis added). This explicit direction to develop a uniform body of federal common law to govern claims payment under both self-funded and insured plans shows conclusively that ERISA's purpose was to occupy the field of plan regulation and civil enforcement, to the exclusion of

all state rules of general application. Indeed, as the Ninth Circuit well knew, the state rules that it preserved could *not* be incorporated into federal common law under ERISA. To do so would violate the basic tenets that the courts, in creating federal common law, cannot " 'defeat the scheme created by Congress in ERISA,' " and that " '[c]laims relating to ERISA plans must . . . invoke the *specific remedies* of ERISA.' " *Pacificare Inc. v. Martin*, 34 F.3d 834, 836 (9th Cir. 1994) (citations omitted) (emphasis added). "Recourse to federal common law is improper when it would be used to rewrite ERISA rather than to implement its policies." *Member Services Life Ins. Co. v. American Nat. Bank and Trust Co. of Sapula*, 130 F.3d 950, 957 (10th Cir. 1997).

Employee benefit plans nationwide are either self-funded or are underwritten and administered in whole or in part by insurance companies or Blue Cross/Blue Shield organizations, all of which stand in the place of the plan's administrator and trustees in handling benefit claims. The processing and review of benefit claims by insurance companies thus constitute an integral part of ERISA plan administration, directly regulated by the Act's fiduciary responsibility provisions in §§ 404 and 503, and regulations promulgated under § 503. Indeed, by treating insurance companies as "named fiduciaries" and subjecting them to the full range of fiduciary duties, both Congress and the Department of Labor have acknowledged that, in this context, insurance companies are proxies for the plan and its administrator and trustees, with the very same fiduciary obligations, liabilities and protections under federal law. ERISA §§ 404, 409, 503, 514(a). Because the Ninth Circuit would insulate this regulation of claims processing and payment from state law if the plan were self-funded, *see, e.g., Moore v. Provident Life & Accident Ins. Co.*, 786 F.2d 922, 926-927 (9th Cir. 1986), its resurrection of state law as the principal mechanism for regulating this area is totally at odds with ERISA's carefully-crafted design. "States are not free to change

ERISA's structure and balance," even by *statute*. *Boggs v. Boggs*, 117 S.Ct. at 1762.

II. The Ninth Circuit Saving Clause Holding Squarely Conflicts With ERISA.

A. *General Common-Law Rules Do Not Constitute Regulation Of The "Business Of Insurance" Under The McCarran-Ferguson Act, Upon Which ERISA's Saving Clause Is Based.*

The Ninth Circuit necessarily held that California's notice-prejudice rule "relates to" employee benefit plan administration within the meaning of ERISA's broad preemption clause in § 514(a). Pet. App. at 5a. The Circuit court then turned its focus to ERISA's saving clause, § 514(b)(2)(A), one of the Act's " '*narrow* exceptions' " to preemption, *Travelers*, 514 U.S. at 657 (citation omitted) (emphasis added). This clause preserves only state law that "regulates insurance."

To be exempt under ERISA's saving clause, a state law must not only pass a "common-sense" test of being specifically aimed at the insurance industry; it must also satisfy the three McCarran-Ferguson criteria, including the transfer of risk of loss, for determining whether the practice the state law seeks to govern is the "business of insurance." *Pilot Life*, 481 U.S. at 48-49. This Court has construed ERISA's saving clause and the narrow definition of the "business of insurance" in the McCarran-Ferguson Act in a similar manner. *Metropolitan Life*, 471 U.S. at 742-743; *Pilot Life*, 481 U.S. at 48-51. Under "state regulation," the McCarran-Ferguson Act specifies that the "business of insurance . . . shall be subject to the laws of the several States which relate to the regulation or taxation of such business." 15 U.S.C. § 1012(a). Under "Federal regulation," it provides that only a narrow range of state law will be exempt from federal preemption. No federal statute shall be construed to "supersede any law *enacted* by any State for the purpose of

regulating the *business of insurance*, or which imposes a fee or tax upon such business," unless the federal act "specifically relates to the business of insurance." § 1012(b) (emphasis added). Accordingly, the McCarran-Ferguson "exemption [from federal preemption] is for the 'business of insurance,' *not* the 'business of insurers.' " *Royal Drug*, 440 U.S. at 211 (citation omitted) (emphasis added).

California's notice-prejudice rule is merely a common-law rule of general application which fails both the "common-sense" test and the three McCarran-Ferguson criteria. In construing the saving clause, the Ninth Circuit disregarded the careful symmetry between the two statutory schemes. "In essence . . . the McCarran-Ferguson Act permits the states to regulate insurance in such primary areas as licensing, underwriting, reserves, insurance policy content, and taxation, but does *not* permit state regulation in areas governed by ERISA, such as plan administration, fiduciary liability, claims-handling and civil enforcement." David L. Bacon, et al., *Employee Benefits Guide* (Matthew Bender & Co.) (1997), § 8.02[1] (emphasis added). In holding that the notice-prejudice rule was shielded, the Circuit court construed the saving clause in a manner that not only is refuted by ERISA's objectives and framework, but also violates the plain meaning of its language.

1. *The Notice-Prejudice Rule Admittedly Does Not Involve The Transfer of Risk, An Essential McCarran-Ferguson Requirement.*

As stated in *Pireno*, 458 U.S. at 127-128, McCarran-Ferguson's first, preeminent requirement is the transfer of risk of loss, which the Ninth Circuit admitted was not triggered by the notice-prejudice rule. Pet. App. at 2a, 5a; *Cisneros*, 134 F.3d at 945-946. The Circuit court summarily dismissed the risk-spreading requirement as unessential. *Id.* This was clear error; the failure to spread risk, by itself, places the notice-prejudice rule far outside the saving clause. This Court has described the activity of spreading and underwriting a policyholder's risk in

forceful, unambiguous terms as one of the "*primary* features of an insurance contract," "an *indispensable* characteristic of insurance" and "a *critical determinant* in identifying insurance." *Royal Drug*, 440 U.S. at 211-213 (emphasis added). In the Court's view, it is "'the *one earmark of insurance* as it has commonly been conceived of in popular understanding and usage.'" *Id.* at 212 (citation omitted) (emphasis added).

Unfortunately, the Ninth Circuit simply seized upon one line of ambiguous dictum in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982), that "none of [the McCarran-Ferguson factors] is necessarily determinative in itelf." From that language the Circuit court somehow concluded that a state common-law rule, such as the notice-prejudice rule, directly impacting ERISA plan administration, could be "saved" even if it did not involve risk transfer.

A common-sense reading of *Royal Drug* and *Pireno* indicates exactly the opposite. In *Pireno*, the Court scrutinized all three McCarran-Ferguson criteria in determining whether the conduct of a peer review committee, which decided whether certain medical provider fees were necessary and reasonable, fit the narrow "business of insurance" exception from antitrust law, and concluded that none was satisfied. 458 U.S. at 129. First, the Court observed that peer review played no part in the spreading or underwriting of risk, because the transfer of risk is effected by the insurance policy and "is complete at the time the contract is entered." 458 U.S. at 130. It also noted *Royal Drug's* observation, 440 U.S. at 220-221, that parts of the legislative history "strongly suggest that Congress understood the business of insurance to be the *underwriting and spreading of risk*." 458 U.S. at 127-128 (emphasis added). As to the second criterion, the Court distinguished between the writing of the insurance policy and its "interpretation and enforcement," explaining that these latter activities were not an integral part of the insured-insurer relationship. *Id.* at 128-129. Finally, the

Court concluded with respect to the third criterion that peer review practices "are not limited to entities within the insurance industry." *Id.* at 132.

The *Pireno* Court's dictum that "[n]one of these criteria is necessarily determinative in itself" provides no support for the proposition that two out of three of the criteria are enough. The *Pireno* Court carefully examined "all the criteria" and found that *each* supported the conclusion that peer review did not constitute the "business of insurance." The Ninth Circuit overlooked this cogent reasoning in *Pireno* and its approval of *Royal Drug's* unambiguous dictate that risk transfer itself is an "'*indispensable* characteristic of insurance.'" 458 U.S. at 127-128 and n.7 (citation omitted) (emphasis added). Read together, Royal *Drug* and *Pireno* establish, at the very least, that all three criteria are significant, and no state law will satisfy the "business of insurance" requirement ***unless*** it involves the transfer of risk—the one "indispensable" insurance characteristic, and a "critical determinant" in identifying insurance. *Royal Drug*, 440 U.S. at 211-213; *Pireno*, 458 U.S. at 127-28 and n. 7. ***See also Barnett Bank of Marion County, N.A. v. Nelson***, 517 U.S. 25, 39 (1996) (the spreading of risk lies "at the core of McCarran-Ferguson . . . concerns"). In ***Anderson v. Humana, Inc.***, 24 F.3d 889, 892 (7th Cir. 1994), the Seventh Circuit accurately captured the difference between state laws that satisfy the "business of insurance" requirement and those that merely embody general common-law principles. It concluded that "insurance" under McCarran-Ferguson "requires some sort of component of risk pooling, and the sort of regulation preserved to the domain of the states is that expressly directed at that insurance component—as opposed to, say, laws of general application that just happen to have some bearing on the affairs of insurers." 24 F.3d at 892.

Indeed, this Court has never found a state law to regulate the "business of insurance" within the meaning of the

McCarran-Ferguson Act *unless* that law involved such matters as insurance taxation, *see* 15 U.S.C. § 1012(a), or a practice directly affecting the spreading and underwriting of the risk of loss, or other matters unique to insurance companies, such as selling and advertising of policies and the licensing of insurers and their agents. *See, e.g., SEC v. National Securities, Inc.*, 393 U.S. 453, 460 (1969) (a state statute aimed at protecting the interests of stockholders in insurance companies does not regulate "business of insurance" under McCarran-Ferguson); *Metropolitan Life, supra* (ERISA "saves" state mandated-benefit statute which satisfies all three McCarran-Ferguson criteria, including risk transfer); *Department of Treasury v. Fabe*, 508 U.S. 491 (1993) (ERISA "saves" portions of a state statute that govern priority of claims against insolvent insurers; all three criteria met).

In line with *Royal Drug, Pireno, Metropolitan Life* and *Pilot Life*, the Fifth Circuit has held that a state law must satisfy *all three* of the McCarran-Ferguson Act criteria for the "business of insurance" to fall within ERISA's narrow saving clause. *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.), *cert. denied*, 117 S.Ct. 387 (1996); *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993). *Tingle* observed that "[t]he Eleventh, Sixth, Tenth and Eighth Circuits have all held that a statute's failure to satisfy one or more of the *Metropolitan Life* factors excludes it from the ERISA saving insurance clause." 996 F.3d at 110. Moreover, seven Circuits have ruled that state laws which fail to transfer an insurance policyholder's risk do not involve the "business of insurance" and therefore are not within the saving clause,[10] and no Circuit court prior to *Cisneros* ever held that a state law came within the saving clause where the essential spreading of risk was not involved.

[10] *Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153-54 (8th Cir. 1990) (state law which fails to transfer risk is preempted), *cert. denied*, 501 U.S. 1238 (1991); *Tingle*, 996 F.2d at 108 (state law which fails to transfer risk is preempted); *Insurance Bd. v. Muir*, 819 F.2d 408, 412 (3d Cir. 1987) (state law which does not affect transfer of risk or satisfy any other McCarran-Ferguson criterion is preempted); *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 940 (6th Cir. 1997) (same); *McMahan v. New England Mut. Life Ins. Co.*, 888 F.2d 426, 428-30 (6th Cir. 1989) (state law which fails to transfer risk or satisfy third criterion is preempted); *DeBruyne v. Equitable Life Assurance Soc.*, 920 F.2d 457, 468-70 (7th Cir. 1990) (same); *Kelley v. Sears, Roebuck & Co.*, 882 F.2d 453, 455-56 (10th Cir. 1989) (state law which fails to transfer risk or satisfy second criterion is preempted); *Anschultz v. Connecticut General Life Ins. Co.*, 850 F.2d 1467, 1468-69 (11th Cir. 1988) (same).

2. *Nor Does The Notice-Prejudice Rule Satisfy The Other Two Essential McCarran-Ferguson Criteria.*

The other two McCarran-Ferguson criteria—namely, the state law is an integral part of the *insurance policy* relationship between insured and insurer, and is limited to entities within the insurance industry—must also be satisfied in order for a state law to be within the saving clause. The Ninth Circuit's peremptory conclusion that these criteria were triggered by the notice-prejudice rule defies common sense and conflicts sharply in principle with this Court's *Metropolitan Life* and *Pilot Life* decisions.

Although frequently "identified with" the insurance industry, California's notice-prejudice rule has its trunk and roots in two common-law contract rules of the broadest general application which apply to *all* private parties, including insurance companies. First, parties to all contracts have a duty to cooperate, including a duty regarding notices, *see Restatement (2d) of Contracts*, § 205, and illustration 7 (insurance policy notice and proof of loss provisions are subject to duty to cooperate), and only a prejudicial breach will relieve the other party of its duty to perform.[11]

[11] *See Aetna Cas. and Surety Co. v. Murphy*, 206 Conn. 409, 538 A.2d 219 (1988) (justifying adoption of notice-prejudice rule on

This contract rule applies not only to insurance contracts in California, *Campbell v. Allstate Ins. Co.*, 60 Cal.2d 303, 305 (1963) ("notice-prejudice" rule based on "cooperation" clause in insurance contract), but also to *every* contract in California. *Universal Sales Corp. v. California Press Mfg. Co.*, 20 Cal.2d 751, 771-772 (1942) (the duty of cooperation exists "[i]n every contract.") Second, state common law generally requires that prejudice must be shown before the failure to perform a contractual obligation or to give a required notice will work a forfeiture. *See, e.g., Conservatorship of Rand*, 49 Cal.App. 4th 835 (1996); *Industrial Asphalt v. Garrett Corp.*, 180 Cal.App.3d 1001 (1986); *see also Restatement (2d) of Contracts*, § 229.

Unlike the mandated-benefits statute in *Metropolitan Life, supra*, the California rules involving "notices" and prejudice are procedural devices which fail to satisfy the second McCarran-Ferguson criterion. This test does not focus on the "relationship" in general, but rather specifically on the insurance "policy relationship" between the insurer and the insured. *SEC v. National Securities*, 393 U.S. at 460. The California rules do not form an integral part of the insurance policy relationship because they do not center on insurance policy content; they do not even define eligibility or the nature, amount or duration of insurance coverage. Instead, the California rules merely change the notice requirements for claims asserted under the contract,[12] and as such they only purport to "regulate[] the *administration* of policies [or contracts], *not* their substantive terms." [13]

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general contract principle of avoiding a disproportionate forfeiture); *Smith, Valentino & Smith, Inc. v. Superior Court of Los Angeles County*, 17 Cal.3d 491, 497 (1976) (prior breach may be *de minimus*).

12 *Davies, supra.*

13 *See Smith v. Jefferson Pilot Life*, 14 F.3d at 570 (ERISA preempts statute requiring notice for cancellation of insurance

Further, under McCarran-Ferguson "the 'business of insurance' should be read to single out one *activity* from others, not to distinguish one *entity* from another." *Hartford Fire Ins. Co. v. California*, 509 U.S. 764, 781 (1993) (emphasis added). The Ninth Circuit applied the California "notice" rule to the *activity* of deciding whether plan benefits are payable. A third-party administrator or an insurance company delegated responsibility for processing claims under an ERISA plan is performing ERISA mandated functions and is not engaged in the business of insurance, *cf. Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423-424 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986). Further, this ERISA-regulated conduct is not subject to suit under state laws. *Pilot Life, supra.* This plan activity does not involve risk-spreading, does not focus on the insurance policy relationship or center on its content, and, accordingly, it does not satisfy the first or second McCarran-Ferguson criteria. Additionally, the activity fails to satisfy the third criterion because it is not limited to the insurance industry. For a multitude of plans, claims adjudication is performed by employers, trustee committees, third-party administrators, or utilization review committees or peer review organizations. *See Pireno, supra.* The ERISA-governed activity of deciding claims, including the review of denied claims pursuant to § 503, does not become the "business of insurance" merely because it is delegated to an insurance company rather than being performed by the Plan Administrator or the plan's trustees.

California's notice-prejudice rule, therefore, no more constitutes a law "regulat[ing] insurance" than any other common-law rule of general application, such as rules

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coverage to be effective) (emphasis added); *Davies*, 128 F.3d at 942 (ERISA preempts statute permitting rescission of insurance policy in case of willful misrepresentation by plan participant; saving clause not applicable because statute does not spread risk or "affect the substantive terms" of the insurance contract).

regarding "ambiguity," "unreasonableness," or "material misrepresentation," "adhesion contract" rules, or extra-contractual liability doctrines. Consequently, the notice-prejudice rule is no more specific to the industry and no more satisfies any of the McCarran-Ferguson criteria than the Mississippi law of "bad faith" addressed by this Court in *Pilot Life*, 481 U.S. at 49-50. Even though the Mississippi Supreme Court had "*identified* its law of bad faith with the insurance industry," this Court concluded that the "*roots* of this law" were "firmly planted in the general principles of Mississippi tort and contract law." *Id.* at 49-50 (emphasis added). As a result, it held that the state law did not pass the "common sense" test for "regulating insurance." *Id.* Further, it held that the law did not satisfy all of the McCarran-Ferguson criteria because it failed to involve the transfer of risk of loss, was "no more 'integral' to the insurer-insured relationship than any State's general contract law," and was not unique to the insurance industry. *Id.* at 50-51.

California's "notice" rule is exactly parallel. While often "identified" with insurance cases, the doctrine does not govern a practice which causes the transfer of risk, affects the substantive coverage provisions of insurance policies, or is limited to insurance companies. Instead, the rule merely derives from general principles of contract law applicable to all California contracts.

This Court's decisions in *Metropolitan Life*, 471 U.S. at 744, and *Pilot Life*, 481 U.S. at 48-50, both illustrate the fundamental flaws in the Ninth Circuit's holding. In *Metropolitan Life*, the state mandated-benefits statute spread the risk of loss to the insurer, it was an integral part of the insurance policy relationship because it required substantive coverage, and it was limited to the insurance industry. Accordingly, the statute not only fit the narrow category of law exempt from federal preemption under McCarran-Ferguson as a "law enacted by [a] State for the purpose of regulating the business

of insurance," 15 U.S.C. § 1012(b), but clearly qualified as a law "regulating insurance" under ERISA's narrow saving clause. Indeed, the statute provided the very example of local regulation which ERISA's saving clause was designed to protect.

Perhaps even more importantly, the mandated-benefit statute's subject matter concerned an area that was not then regulated by ERISA at all—the coverage provided by employee welfare benefit plans—and accordingly involved none of the preeminent regulatory concerns present here. Thus, *Metropolitan Life* lacked the direct conflict between federal and state law which necessarily provided a critical and decisive element in *Pilot Life* and is present here. *Metropolitan Life* acknowledged, moreover, that ERISA foreclosed *direct* state regulation of employee benefit plans. 471 U.S. at 747. Clearly, state regulation of a plan fiduciary's review of a claim, irrespective of the plan's funding mechanism, directly intrudes on ERISA fiduciary standards and the plan's administration, and cannot be sustained. Indeed, the Ninth Circuit decision will impose a multiplicity of conflicting federal-state laws on ERISA plan administration and *surrender* one of its most significant portions—the payment of plan benefits—to fifty different sets of state law rules.

Not only was the issue presented in *Metropolitan Life* separate and distinct from that involved here, but the consequences for employee benefit plan administration are far different. *Metropolitan Life* recognized only that "national plans" would face some "disuniformities" if they "enter[ed] into local markets to purchase insurance." 471 U.S. at 747. In contrast, the Ninth Circuit decision will generate more than mere "disuniformity"—it will frustrate the very principles central to ERISA's statutory scheme. Unlike *Metropolitan Life*, this dysfunction cannot be viewed simply as an incidental, but "inevitable result" of Congress' desire to save state insurance regulation. Rather, these consequences are directly contrary to Congress' purposes in enacting ERISA.

The Ninth Circuit's erroneous application of the three McCarran-Ferguson criteria will have a harsh impact in the area of ERISA plan regulation and will apply in all other McCarran-Ferguson cases, disrupting long-standing law in that area.

B. *Even If Otherwise Applicable, The Saving Clause Would Not Shield State Laws Directly Conflicting With ERISA's Statutory Provisions Or Objectives, Including Its Exclusive Civil Enforcement Scheme.*

Even if the notice-prejudice rule otherwise fell within the narrow saving clause, the exemption would not shield the rule because it directly conflicts with ERISA's statutory provisions and frustrates its objectives, including the exclusive civil enforcement scheme. *See Harris Trust*, 510 U.S. at 99 n.9; *Pilot Life*, 481 U.S. at 51-57.

This Court has acknowledged that an understanding of ERISA's saving clause must be informed by "the legislative intent" and "the role of the saving clause in ERISA *as a whole*." *Pilot Life*, 481 U.S. at 51-52 (emphasis added). In *Pilot Life*, the Court held that Congress intended ERISA's civil enforcement mechanisms in § 502, similar to those under § 301 of the Labor-Management Relations Act ("LMRA"), to be the *exclusive* remedy in claims disputes and to have their own "pre-emptive effect." *Id.* at 51-52, 55-57. Applying conflicts analysis, it then held that even if a state common-law claim based on the nonpayment of benefits could somehow be deemed a law regulating insurance, the saving clause must be read as part of ERISA as a whole and, therefore, will not shield state laws that conflict with any of the Act's substantive provisions, or provide a remedy beyond what is contained in its carefully-drawn civil enforcement provisions.

California's common-law notice-prejudice rule directly conflicts with several of ERISA's central statutory provisions and its main objectives and, accordingly, the rule is barred under traditional conflicts analysis. First, as the Ninth Circuit conceded in *Cisneros*, the notice-prejudice rule causes "a plan's written terms [to be] *altered*." 134 F.3d at 947. Thus, the rule squarely conflicts with ERISA's fiduciary standards in § 404 including the "written plan instrument" rule, which secures several of Congress' most important purposes. It assists in ensuring the nationally uniform administration of employee benefit plans, *see Travelers*, 514 U.S. at 657, thus allowing interstate employers to predict the legality of proposed actions " 'without the necessity of reference to varifying state laws,' " *Pilot Life*, 481 U.S. at 56 (citation omitted). Of equal importance, it also "*protect*[*s*] *the financial integrity* of pension and welfare plans by *confining* benefits to the terms of the plan as written." *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126, 128 (7th Cir. 1992) (Posner, J.) (emphasis added).

Second, the notice-prejudice rule squarely conflicts with ERISA's exclusive civil enforcement provisions in § 502(a) which protect exactly the same congressional goals. ERISA authorizes suit for benefits *only* if they are "due" under the plan's written terms, *Pilot Life*, 481 U.S. at 52-57, a suit that "falls directly under § 502(a)(1)(B) which provides an *exclusive federal cause of action*." *Metropolitan Life Ins. Co. v. Taylor*, 481 U.S. 58, 62 (1987) (emphasis added). In direct conflict with these commands, the Ninth Circuit adopted the notice-prejudice rule to furnish a state remedy under which benefits are *not* "confin[ed] . . . to the terms of the plan as written." *Pohl, supra.* The lower court's decision thus clashes with the very purpose underlying § 502(a):

> In sum, the detailed provisions of § 502(a) set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans. The policy choices reflected in the inclusion of certain remedies and the exclusion of others . . . would be completely undermined if ERISA-plan participants . . . were free to obtain remedies under state law that Congress rejected in ERISA.

Pilot Life, 481 U.S. at 54.

Apart from the Ninth Circuit, the Courts of Appeals have consistently held that ERISA bars the use of any common-law doctrines which either conflict with its carefully-drawn statutory framework, or cause a departure from the written plan instrument.[14] Similarly, these Courts of Appeals have held that ERISA preempts state common-law "notice" rules or "notice" statutes.[15] The rationale behind these decisions is that such state laws fall within ERISA's broad preemption clause in § 514(a), and conflict either with the sponsor's freedom of plan design or the Act's comprehensive regulatory scheme.

California's notice-prejudice rule also conflicts with yet another ERISA provision central to the statutory scheme —the orderly internal resolution of benefit disputes as a prerequisite to filing suit under the Act's exclusive civil

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[14] *See, e.g., Nachwalter v. Christie*, 805 F.2d 956, 960 (11th Cir. 1986) ("federal courts may not use state common law to rewrite a federal statute"); *Member Services Life Ins. Co.*, 130 F.3d at 957-58 (courts cannot "rewrite [ERISA] to satisfy [their] proclivities"); *Pohl*, 956 F.2d at 128 (same); *Northeast Department ILGWU v. Teamsters Local No. 294*, 764 F.2d 147, 158 n.8 (3d Cir. 1985) (judge-made rules of interpretation of insurance contracts are not the kind of insurance regulation Congress intended to preserve); *Edwards v. Great-West Life Assur. Co.*, 20 F.3d 748, 750 (7th Cir. 1994) (courts cannot "rewrit[e] the plan"); *Burnham v. Guardian Life Ins. Co.*, 873 F.2d 486, 490 (1st Cir. 1989) (same); *Coleman v. Nationwide Ins. Co.*, 969 F.2d 54, 56, 59 (4th Cir. 1992) (same), *cert. denied*, 506 U.S. 1081 (1993). *But see O'Connor, supra*, adopting the *Cisneros* holding.

[15] *See, e.g., Nazay v. Miller*, 949 F.2d 1323, 1336-37 (3d Cir. 1991) (ERISA preempts "notice-prejudice" rule with respect to self-funded plan); *Howard v. Gleason Corp.*, 910 F.2d 1154, 1157-58 (2d Cir. 1990) (ERISA preempts state statute requiring a terminated employee be notified of insurance conversion options); *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 571 (11th Cir.) (ERISA preempts state statute governing notice to insured of termination of coverage), *cert. denied*, 513 U.S. 808 (1994); *Doe v. Blue Cross & Blue Shield United*, 112 F.3d 869, 874-875 (7th Cir. 1997) (ERISA plan's internal limitations period controls over state statute).

enforcement system. Notice of claim deadlines are standard features of many ERISA plans, and protect against the difficulties of proof, expenses and errors associated with stale claims.[16] A plan's written procedures, and time limits for the filing of claims, 29 C.F.R. § 2560.503-1(b), (c), no less than the fiduciary review procedure required by ERISA § 503, are essential steps in the plan's administrative remedies.[17] The Ninth Circuit did not find that the time provided by the Plan for submitting notice of claim, one year and 180 days, failed to be "reasonable." 29 C.F.R. § 2560.503-1(b), (c), (d). A core part of this Court's *Pilot Life* holding is that ERISA suits for plan benefits must arise under federal law in a manner similar to those under § 301 of the LMRA. 481 U.S. at 55-56. Under § 301, an agreement's administrative remedies, including its written time limits for filing a claim, must be followed as a prerequisite to filing suit.[18] In this case, because of Ward's admittedly late submission, *no* benefits were *"due . . .* under the terms of [the] plan." ERISA § 502(a)(1)(B) (emphasis added). In order to write an opinion that would permit Ward's suit to proceed nonetheless, the Ninth Circuit was virtually required to shred ERISA's carefully-drawn text governing fiduciary stand-

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[16] *Central States, Southeast and Southwest Areas Pension Fund v. Mississippi Warehouse Corp.*, 853 F. Supp. 1053, 1058 (N.D. Ill. 1994); *Tiger v. AT&T Tech. Plan for Employees' Pensions, Disability Plan*, 633 F. Supp. 532, 534 (E.D. N.Y. 1986).

[17] *See Kinkead v. Southwestern Bell Sick. & Acci. Corp. Disability Benefit Plan*, 111 F.3d 67, 68 (8th Cir. 1997); *Kennedy v. System One Holdings, Inc.*, 835 F. Supp. 947, 950 n.3 (S.D. Tex. 1993); *Christie v. K-Mart Corp. Employees Retirement Pension Plan*, 784 F. Supp. 796, 804 (D. Kan. 1992); *see also White v. Jacobs Engineering Group Long Term Disability Plan*, 896 F.2d 344, 346-47 (9th Cir. 1990) (plan's 60 day time limit for appealing denied claim is enforceable).

[18] *See, e.g., Laws v. Calmat*, 852 F.2d 430, 434 (9th Cir. 1988); *Brazinski v. Amoco Petroleum Additives Co.*, 6 F.3d 1176, 1179 (7th Cir. 1993); *Vaca v. Sipes*, 386 U.S. 171, 184-85 (1967).

ards, claims review procedures and the civil enforcement mechanisms.

This Court has stated that "[t]he authority of courts to develop a '*federal* common law' under ERISA . . . is *not* the authority to revise the text of the statute." *Mertens*, 508 U.S. at 259 (citation omitted) (emphasis added). So, too, the federal courts cannot "save" *state* common-law rules in order to accomplish the same impermissible end. "[V]ague notions of a statute's 'basic purpose' "—*including* the "goal of 'promot[ing] the interests of employees and their beneficiaries in employee benefit plans' "—cannot be used to "overcome the words of its text regarding the *specific* issue under consideration." *Id.* at 261-262. Instead, a plaintiff such as Ward must be able to point to a specific section of ERISA which "affirmatively *authorizes*" the relief sought, *id.* at 255 n.5, a critical element he admittedly cannot satisfy because the statute itself requires the claim denial. ERISA §§ 404 and 502. The carefully-crafted nature of ERISA's statutory scheme precludes the Ninth Circuit's efforts to rewrite and "fine-tune" the statute in favor of participants. *Massachusetts Mutual Life Ins. Co. v. Russell*, 473 U.S. at 147-148; *Pilot Life*, 481 U.S. at 54.

C. *Additionally, ERISA And McCarran-Ferguson Would Bar Any State Laws Directly Impacting An ERISA Fiduciary's Claims-Handling For An Insured Plan.*

Even if the notice-prejudice rule somehow were deemed a law "regulating insurance," ERISA and the McCarran-Ferguson Act would preempt its application to fiduciaries performing the ERISA mandated function of reviewing denied claims for insured plans pursuant to § 503.

First, as noted by this Court in *Travelers*, 514 U.S. at 651, Congress significantly "limited" the already narrow scope of ERISA's saving clause by adding the "deemer" clause, which precludes any plan from being "deemed" an "insurance company" or "engaged in the business of insurance . . . ." ERISA § 514(b)(2)(B), 29 U.S.C.

§ 1144(b)(2)(B). The "deemer" clause prohibits state insurance law from interfering with plan operations including an insurance company performing a mandated ERISA function on behalf of a plan, such as reviewing denied claims pursuant to § 503.

This significant qualification to the saving clause reflects, in unmistakable terms, Congress' objective to free the *administration* of insured plans from the possibility of direct state regulation through some artful or overly-broad construction of the insurance exception. When the "deemer" clause is read in conjunction with ERISA's purposes, it is clear that the Act preempts state regulation directed to fiduciary conduct and plan administration—regulation which strikes at the heart of ERISA—even where the plan is administered in part through an insurance company. Instead, the insurance company, in its role as claims review fiduciary under § 503, stands in the shoes of the plan's administrator and trustees and is subject to the same exacting ERISA fiduciary standards including § 404(a)(1)(D). The "deemer" clause thus prevents interference with the insurance company's plan activities. This Court recognized that point in *Metropolitan Life*, 471 U.S. at 741, where it determined that the "deemer" clause was intended to "exemp[t] from the savings clause laws regulating insurance companies that apply directly to benefit plans."

Second, even were this Court to conclude that an ERISA fiduciary's administration of claims somehow constituted the "business of insurance," a joint application of ERISA and the McCarran-Ferguson Act would also bar application of the notice-prejudice rule.[19] McCarran-Ferguson specifies, consistent with federal supremacy principles, that federal legislation which "*specifically relates*"

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[19] By its express terms, ERISA does not "alter, amend, modify, invalidate, impair, or supersede any law of the United States . . . or any rule or regulation issued under any such law." ERISA § 514(d), 29 U.S.C. § 1144(d). The McCarran-Ferguson Act is such a pre-existing law. *See Metropolitan Life*, 471 U.S. at 744 n.21.

to the business of insurance will displace any conflicting state law. 15 U.S.C. § 1012(b) (emphasis added).

As demonstrated, ERISA exclusively and directly governs fiduciary standards by requiring that *all* plans, both self-funded and insured, be in writing and be administered strictly "in accordance with" their written terms; it mandates a fiduciary review procedure for denied claims pursuant to § 503; and it also provides an *exclusive* civil enforcement scheme that limits recovery to benefits "due" under the plan's written terms. ERISA §§ 402(a)(1), 404(a)(1)(D), 503, 502(a)(1)(B). If a notice-prejudice rule which impacts fiduciary standards, plan administration and suits for benefits "regulates the relationship between insurer and insured,"[20] then *a fortiori* ERISA also "specifically relates" to the business of insurance in this context. As a result, ERISA and McCarran-Ferguson would operate in conjunction to preempt the notice-prejudice rule pursuant to 15 U.S.C. § 1012(b). *See Harris Trust*, 510 U.S. at 99-100 (ERISA preempts state regulation of the "business of insurance" if it presents a "'direct conflict'" with federal law or "'stands as an obstacle to the accomplishment of the full purposes and objectives of Congress'" (citation omitted)). As the Ninth Circuit acknowledged in an analogous context:

> Asuming arguendo that [the state law] is a state law regulating insurance . . . appellant's argument . . . ignores those ERISA sections that undeniably 'specifically relate' to the business of insurance. . . . If McCarran-Ferguson applies, therefore, ERISA falls within the clause excepting federal laws that 'specifically relate' to the business of insurance.

Hewlett-Packard Co. v. Barnes, 571 F.2d 502, 505 (9th Cir.), *cert. denied*, 439 U.S. 831 (1978).

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[20] *See O'Connor*, 146 F.3d at 963, a decision adopting the *Cisneros* holding.

III. The Ninth Circuit Preemption Clause Holding Squarely Conflicts With ERISA.

The Ninth Circuit decision that the *Elfstrom* rule escapes preemption directly conflicts with ERISA's comprehensive statutory scheme, and once again flouts *Pilot Life* and the carefully-articulated preemption standards in *Travelers, Dillingham* and *Ingersoll-Rand*. Ignoring this Court's preemption jurisprudence, the Circuit court failed to analyze correctly whether California agency law even "relates to" an ERISA plan within the meaning of § 514(a), much less whether it is barred by field or conflicts preemption. Instead, it mechanically applied state agency law based on a single, impliedly-overruled case, *Turrill v. Life Ins. Co. of North America*, 753 F.2d 1322 (5th Cir. 1985), which permitted state law to govern a suit for benefits under an insured ERISA plan. The Circuit court failed to recognize that *Turrill* was decided *prior* to *Pilot Life* at a time when the courts consistently but incorrectly believed ERISA preemption did not apply to such suits.[21]

A. Elfstrom *Is A Pre-ERISA Attempt By The California Supreme Court To Regulate The Adminstration Of Employee Benefit Plans.*

If ever there were a pre-ERISA state rule designed to regulate group insurance plan administration, it is the one adopted by the 1967 *Elfstrom* decision. The California case involved a plaintiff business owner whose employees and families were covered by an employer-sponsored group medical and life insurance policy issued by New York Life. When Mr. Elfstrom's daughter reached majority, he instructed his secretary to ensure that she remained covered. The secretary sent New York Life an application card which falsely represented that the daughter was a full time employee when in fact she had returned to school. *Elfstrom*, 67 Cal.2d at 506-507. The

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[21] Indeed, *Turrill* was decided by the same Fifth Circuit panel, *see Dedeaux v. Pilot Life Ins. Co.*, 770 F.2d 1311 (5th Cir. 1985), which this Court reversed two years later in *Pilot Life*.

daughter died shortly thereafter. New York Life denied payment because she was ineligible under the insurance policy's written terms.

In deciding this case, the California Supreme Court realized it had encountered the "relatively new social device" of "group insurance." Determined to compel payment, it held that the secretary was acting as New York Life's agent, reasoning that an employer which performs administrative functions in support of a group insurance plan must act under the insurance company's direction, and that the secretary's knowledge could be imputed to the insurer. 67 Cal.2d at 505-506, 510, 512, 514. Under the *Elstrom* doctrine, the insurer possesses all control over a group insurance plan, with the employer-sponsor becoming a mere functionary. This proposition is the exact reverse of ERISA's carefully-crafted statutory scheme that was enacted seven years later and now governs this case.

B. *The* Elfstrom *Rule Plainly Relates To An ERISA Plan.*

ERISA preempts the *Elfstrom* rule because it "relates to" an ERISA plan within the meaning of § 514(a) inasmuch as it has a "reference to" or "connection with" the plan. *Shaw*, 463 U.S. at 96-97.

Elfstrom plainly satisfies the "reference to" test because it purports to regulate the ERISA plan's operation and payment of benefits. Here, the Plan explicitly dictates the nature and scope of the agency relationship between MAC and UNUM. It provides that the employer is the Plan Administrator and not the agent of UNUM. Pet. App. at 44a. Application of *Elfstrom* reads this provision out of the Plan and substitutes a different and conflicting provision based on California law. Indeed, Ward is attempting to use state law to assert the timely, oral "filing" of an ERISA claim with MAC, and to bind the Plan to such "filing" and obtain benefits that are specifically barred by the Plan's written terms. The state law thus has a direct and immediate "reference to" an

ERISA plan and is preempted pursuant to § 514(a). *See Pilot Life*, 481 U.S. at 47-48; *District of Columbia v. The Greater Washington Bd. of Trade*, 506 U.S. 125, 129 (1992); *Dillingham*, 117 S.Ct. at 841.

Elfstrom also satisfies the "reference to" test because it depends on the *existence* of an ERISA plan. *Ingersoll-Rand*, 498 U.S. at 140 (ERISA preempts where the "existence of a . . . plan is a critical factor in establishing liability under state law"). *Elfstrom's* "reference to" ERISA plans is obvious because it regulates plan administration and benefit payment where an employer has established a group insurance plan to provide welfare benefits and serves as Plan Administrator. This type of private sector plan will, in almost all instances, be an ERISA plan. ERISA § 3(1); *see Donovan v. Dillingham*, 688 F.2d 1367, 1373 (11th Cir. 1982) (*en banc*). Because *Elfstrom* applies almost exclusively to ERISA plans, preemption arises due to the fact that "the existence of ERISA plans is essential to the law's operation." *Ingersoll-Rand*, 498 U.S. at 140. In *Jass v. Prudential Health Care Plan, Inc.*, 88 F.3d 1482, 1488-1489 (7th Cir. 1996), the Seventh Circuit held that § 514(a) preempted a state agency law suit to hold a plan responsible for a medical provider's conduct in denying plan benefits. The Court found that the agency argument was based on the plan's existence, triggering preemption under *Ingersoll-Rand*.

Elfstrom also plainly has a "connection with" ERISA plans, and is preempted, because, as shown below, it directly clashes with ERISA's statutory structure including its fiduciary responsibility rules and plan administration provisions. *See Travelers*, 514 U.S. at 656; *Dillingham*, 117 S.Ct. at 838; *FMC Corp.*, 498 U.S. at 59; *Jass*, 88 F.3d at 1488-1489 (ERISA preempts agency rule because it has " 'the effect of regulating the structure or administration of ERISA plans' ") (citation omitted). Even if the *Elfstrom* rule did not clash with ERISA, § 514(a) would still preempt the rule. For example,

in *Howard v. Gleason Corp.*, 901 F.2d 1154 (2d Cir. 1990), the Second Circuit considered a New York statute that required employers to provide specified notice to terminated employees about insurance conversion privileges. The Court held that ERISA preempts the state law because it "purports to impose on an employer obligations of the same general type as those imposed by ERISA." *Id.* at 1157. Rejecting the argument that the New York law should escape preemption because it "does not conflict with any express provision of ERISA in the sense that both laws could be enforced side by side," the Second Circuit held that ERISA preempts the state statute because it "intrudes into an area that Congress intended to be fully occupied by federal statute." *Id.* at 1158. *See also Jass,* 88 F.3d at 1493.

In cases where the direct relationship between the plan and the state law is not so immediately obvious as the one here, this Court has held that whether the law has a "connection with" the plan and thus is preempted by ERISA § 514(a) should be based on " 'the objectives of the ERISA statute . . . as well as to the nature of the effect of the state law on ERISA plans.' " *Dillingham,* 117 S.Ct. at 838 (citation omitted). The *Elfstrom* rule frustrates ERISA's goals by imposing different regulations from state to state, and by permitting claimants to obtain "benefits in excess of what plan administrators intended to provide, and in excess of what the plan provided to employees in other States." *Travelers,* 514 U.S. at 660, 656-657, 658.

C. *The* Elfstrom *Rule Directly Conflicts With ERISA's Substantive Terms Governing Plan Administration.*

Conflicts preemption bars the *Elfstrom* holding that an employer administering an insured employee benefit plan acts as the agent of the insurer. The holding is directly contrary to ERISA's statutory scheme. Specifically, an employer establishing an employee benefit plan is not only the "Plan Sponsor," but also the "Plan Administrator" absent designation of another party as

administrator. ERISA § 3(16)(A), (B). Consequently, the employer itself possesses the *sole* authority to "control and manage the operation and administration of the plan" under ERISA § 402(a), except to the extent it has delegated fiduciary obligations to another party pursuant to § 402(b)(2). 29 U.S.C. § 1102(a), (b); *see* ERISA § 3(21)(A). Further, ERISA requires the Plan Administrator to act "solely in the interests of the participants and beneficiaries," ERISA § 404(a); thus, the employer could not also act as an "agent" of any other principal, as *Elfstrom* dictates, and cause the plan to be administered contrary to its written terms in violation of § 404(a)(1)(D).

Federal supremacy principles also bar *Elfstrom's* superimposition of state agency law onto the federal regulatory scheme because the state law directly conflicts with the Act's specific fiduciary and co-fiduciary responsibility rules in §§ 409(a) and 405(a)(1), (3). 29 U.S.C. §§ 1109(a), 1105(a)(1), (3).

ERISA imposes *personal* liability on a fiduciary for its *own* breach of any of its "responsibilities, obligations, or duties" under ERISA. ERISA § 409(a); *Massachusetts Mutual Life Ins. Co. v. Russell,* 473 U.S. at 139. *See also Perkins v. Time Ins. Co.,* 898 F.2d 470 (5th Cir. 1990) (under ERISA, personal liability of another party cannot be imputed to insurer under agency law theory). The Ninth Circuit, however, permitted Ward to proceed on a state law agency theory that UNUM, as a "principal" and co-fiduciary, was personally liable for any ERISA violation by MAC in failing to ensure that he timely filed a written notice and proof of claim with UNUM. MAC gave Ward the certificate of coverage which described the Plan's claims procedures, and he attended a number of meetings at which he reviewed the Plan. ERISA did not require MAC, as the Plan Administrator, to do still more for its CEO. ERISA's reporting and disclosure rules "may not be a foolproof informational scheme, although it is *quite thorough.* Either way, *it is the scheme*

that Congress devised." *Curtiss-Wright*, 514 U.S. at 84 (emphasis added).

Even if, as did not occur, MAC had violated ERISA by failing to seek Ward out to give him further, specialized information about claims-filing, the Ninth Circuit still erred in permitting him to use state law agency doctrine to impute such a violation to UNUM as a co-fiduciary. ERISA explicitly places the reporting and disclosure obligations *personally* on the Plan Administrator, §§ 405 (b)(1), 502(c), and no other party can be held liable for such a violation, as the Ninth Circuit has recognized. *Moran v. Aetna Life Ins. Co.*, 872 F.2d 296, 300 (9th Cir. 1989). *See also McKinsey v. Sentry Ins. Co.*, 986 F.2d 401 (10th Cir. 1993). Additionally, ERISA's co-fiduciary liability rules impose liability only where the co-fiduciary has *actual knowledge* of a breach by its co-fiduciary but fails to act. ERISA § 405(a)(1), (3).[22] Within the Plan's time limit for filing written notice and proof of claim, UNUM had no knowledge that Ward claimed to be "disabled" or had purportedly so advised his employer.

The *Elfstrom* rule adopted by the Ninth Circuit overturns ERISA's statutory scheme for fiduciary and co-fiduciary responsibility and civil enforcement.[23]

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[22] H.R. Rep. No. 93-1280, 304 (1994) (actual knowledge is required; there is no duty of investigation); *Davison v. Cook*, 567 F. Supp. 225, 237 (E.D. Va. 1983), *aff'd mem.*, 734 F.2d 10 (4th Cir.), *cert. denied*, 469 U.S. 899 (1984); *Justice v. Bankers Trust Co., Inc.*, 607 F. Supp. 527, 536 (D.C. Ala. 1985).

[23] Even if Ward could argue that ERISA fiduciary duties were somehow breached, ERISA would not provide relief. ERISA does *not* authorize a suit for breach of fiduciary duties in order to obtain individual monetary relief, *Russell*, 473 U.S. at 146-147, *Varity Corp. v. Howe*, 516 U.S. 489 (1996), especially in violation of the plan's written terms. ERISA § 502(a)(1)(B), (a)(2). Even if a participant sues for individualized equitable relief under § 502(a)(3), this section only permits a suit to "*enforce* . . . the terms of the plan" or the "provisions" of ERISA itself (emphasis added).

D. *The* Elfstrom *Rule Directly Clashes With ERISA's Exclusive Civil Enforcement Mechanism.*

The exclusivity of ERISA's civil enforcement scheme also compels preemption of the *Elfstrom* rule.

By statute, all ERISA fiduciaries must strictly follow the plan's written terms, ERISA § 404(a)(1)(D), including the fiduciary conducting the review procedure under § 503; correspondingly, a participant may only file suit to recover benefits "*due* . . . under the *terms* of [the] plan," ERISA § 502(a)(1)(B) (emphasis added). This closely-interlocked structure for fiduciary responsibility and civil enforcement is "the exclusive remedy for rights guaranteed under ERISA." *Ingersoll-Rand*, 498 U.S. at 144.

In an attempt to suggest otherwise, the Ninth Circuit opined: "[N]or does *Elfstrom* create an 'alternate enforcement mechanism' for ERISA plan obligations beyond those set forth in the statute." Pet. App. at 21a-22a. This conclusion is 180 degrees off course. The decision below provides the clearest possible example of an "alternate enforcement mechanism" triggering ERISA preemption. It permits a state law rule to require consideration of plan benefits precisely when a claim denial is mandated by the plan itself, ERISA's fiduciary responsibility rules and its exclusive civil enforcement scheme. As the Seventh Circuit recognized in *Jass, supra*, ERISA preempts the state agency law because it is a mechanism for seeking *benefits* not permitted by the plan documents. 88 F.3d at 1488-1489.

IV. Unless Reversed, The Ninth Circuit Decision Will Seriously Disrupt The Administration Of The Nation's Employee Benefit Plan System.

Unless reversed, the Ninth Circuit decision will cause serious disruptions in the administration of the nation's employee benefit plan system, to the ultimate detriment of the plans and their participants.

Congress built ERISA on the premise the employers should be *encouraged* to provide a voluntary, financially stable system of employee benefit plans. *See* ERISA § 2(a). Throughout its consideration of ERISA, Congress "was acutely aware that under our voluntary pension system the cost of financing pension plans is an important factor in determining whether a pension plan will be adopted." 120 Cong. Rec. 29,953 (1974) (remarks of Sen. Nelson). Congress recognized that if costs were made overly-burdensome, plans would neither be established nor expanded, and an extensive private retirement system would not develop. *Id.* at 29,944-45 (1974) (remarks of Sen. Long).

If the Ninth Circuit decision is allowed to stand, the very economic disincentives Congress hoped to avoid in ERISA will become a reality. By exposing ERISA plans to conflicting state common-law regulation, the costs of funding employee benefit plans will increase significantly. Litigation costs will increase as will the cost of claims investigations, thus invalidating pricing assumptions. These costs will fall not only on employers and the insurance industry, but also on the very individuals ERISA was established to benefit—plan participants. Faced with the increased cost of providing coverage, employers may decide to reduce benefits, or to terminate their plans. Employees, on the other hand, may find the health or pension protection that they have come to rely on significantly cut back or denied altogether. This can hardly be what Congress envisioned when it established a federal regulatory scheme to foster "a private insurance system that would operate efficiently, thereby increasing its acceptance and institution among American business." *Taylor v. Bakery & Confectionery Union & Industry International Welfare Fund*, 455 F.Supp. 816, 820 (E.D.N.C. 1978).

Specifically, the Ninth Circuit's new ERISA preemption standard is so narrow and restricted that it reopens a

door closed by *Pilot Life* to suits against the plan based on virtually any state law claim arising out of a benefit denial. Participants in California will now be able to sue for benefits under circumstances where benefits are not payable under the same plan in Texas, Florida or dozens of other states. This will only encourage further costly litigation to pry open other aspects of employee benefit plan administration, all contrary to Congress' goal of regulating ERISA plans through a "uniform body" of federal "benefits law." *Travelers*, 514 U.S. at 645.

Similarly, because the Ninth Circuit has abandoned the benchmark "business of insurance" standard, namely, the transfer of risk of loss, the Circuit's new standard for construing ERISA's saving clause is so broad and indeterminate that it will arguably include virtually any common-law rule of general application that can be identified with the insurance industry. This list is ever-expanding. For example, California has numerous rules dealing with interpretation of insurance contracts, *e.g.*, *Delgado v. Heritage Life Ins. Co.*, 157 Cal.App.3d 262, 271 (1984) (exclusions and limitations are "strictly construed against the insurer and liberally interpreted in favor of the insured"); *Willden v. Washington Nat'l Ins. Co.*, 18 Cal.3d 631, 635 (1976) ("process of nature rule" relates disability date to the time of the accident). California law now also makes an insurer "forfeit" certain policy rights, *Sarchett v. Blue Cross of Calif.*, 43 Cal.3d 1 (1987) (violation of covenant of good faith and fair dealing caused forfeiture of policy's arbitration clause), and has special limitations on rescission of insurance contracts, *e.g.*, California Insurance Code, § 10350.2. None of these laws "spreads risk," but might be, arguably at least under the Ninth Circuit's expansive standard, preserved by the saving clause even though they directly clash with ERISA's statutory scheme for plan administration.

To allow common-law rules in the fifty states to encroach on ERISA's exclusive framework for fiduciary

obligations and plan administration—and to "alter" the plan's written terms, and to permit a suit for benefits contrary to those terms—completely disrupts any possibility of the "nationally uniform administration" of plans under federal law, a principal congressional goal. *Travelers*, 514 U.S. at 657. In some states, such as Illinois and Michigan, plans will be able to continue to enforce written time limits for submitting claims, as permitted in ERISA; in other states, such as California, they will not be able to do so. In some states, plan fiduciaries may continue to follow uniform federal law in discharging their obligations; in other states, such as California, they will face conflicting federal-state directives on the most essential plan administration feature, the payment of benefits. All of this conflict in law will create vast confusion and difficulty as well as increased expense in ERISA plan administration.

The adverse consequences of the Ninth Circuit decision, moreover, will extend far beyond plan administration within the Ninth Circuit. ERISA provides for nationwide service of process, and permits a suit to be filed in any district where the plan is administered, the breach of fiduciary duty took place, or a defendant resides or may be found. ERISA § 502(e)(2), 29 U.S.C. § 1132 (e)(2); *see, e.g., Varsic v. United States Dist. Ct.*, 607 F.2d 245, 248 (9th Cir. 1979). Sponsors need to be able to design insured and self-funded pension and welfare plans without fear that their written terms will be overturned in one state or another through an erroneous application of ERISA's preemption and saving clauses. Depriving employers of the discretion over plan design will only provide a strong disincentive to establish such plans in the first place. *See, e.g., Health v. Varity Corp.*, 71 F.3d 256, 258 (7th Cir. 1995).

Unless this Court reverses the Ninth Circuit decision, it will be impossible for ERISA plan administrators and fiduciaries to predict or even identify the " 'uniform body' "

of federal benefits law, which was a "basic thrust" of ERISA. *Travelers*, 514 U.S. at 656-657. It will also be impossible for them to administer their plans both in compliance with the plans' written terms and the Ninth Circuit decision. The administrators and fiduciaries cannot know whether to deny a claim on the basis of a clear plan limit, or to accept the claim under state law without regard to the terms of their plan and thus breach an ERISA fiduciary duty. They cannot even know which opposing sets of federal and state laws to apply to determine those questions.

The Ninth Circuit decision also will create an anomalous, confusing split between the administration of self-funded plans which would not be subject to the universe of common-law rules such as notice-prejudice and *Elfstrom*, insured plans which would be, and self-funded plans with stop-loss coverage where a claim presumably would not be until it reached the stop-loss attachment point. Indeed, many plans include not only a number of benefits, some self-funded and some insured, but also a single time limit for filing all claims. Adding to this confusion, many states have rejected the notice-prejudice rule, and it varies considerably across the land, *see* 13A George J. Couch, *Couch Cyclopedia of Insurance Law*, § 49.49 at 276-277 (2 ed. 1982); similarly, state agency law doctrines vary from jurisdiction to jurisdiction. All of this practical uncertainty coupled with the striking differences in law from state to state will create strong financial incentives for employers to cut back or eliminate benefits, directly contrary to ERISA's objectives. ERISA § 2(a), (b); *Pilot Life*, 481 U.S. at 54; *FMC Corp.*, 498 U.S. at 60.

The illogical and haphazard results produced by the Ninth Circuit decision are disruptive to the nation's employee benefit plan system, and the exact reverse of what Congress intended. This Court should reverse the judgment below to restore the preeminence of ERISA's

statutory scheme over employee benefit plan regulation and to give effect to the congressional purposes underlying ERISA.

CONCLUSION

For the foregoing reasons, the decision of the Ninth Circuit Court of Appeals should be reversed and the case remanded with instructions to affirm the summary judgment in favor of the Plan and UNUM.

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UNUM LIFE INSURANCE CO. OF AMERICA,
Petitioner

v.

JOHN E. WARD,
Respondent

On Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

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QUESTIONS PRESENTED

1. Whether the California "notice-prejudice" rule, which prevents an insurance company from avoiding payment of benefits on the basis of untimely notice of the claim unless the insurer can establish that it has been substantially prejudiced by the delay, is a state law that "regulates insurance" and is therefore saved from preemption by Section 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A).

2. Whether general state law principles of agency — under which an employer may, if the insurer chooses to involve the employer in administration of an insured benefits plan, be deemed the agent of the insurance company — "relate to" an ERISA plan within the meaning of the ERISA preemption clause, Section 514(a), 29 U.S.C. § 1144(a).

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STATEMENT OF THE CASE

Respondent John E. Ward's career as pr esident and CEO of Management Analysis Company ("MAC") ended in May 1992 as a result of severe pain caused by diabetic neuropathy. Since then Ward has been permanently disabled and unable to work.

MAC maintained a long-term disability plan for its employees, which qualified as an employee welfare plan under § 3(1) of the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1003(1). MAC administered the plan, which provided benefits by purchasing a disability insurance policy from petitioner UNUM Life Ins. Co. of America. Ward had premiums for disability coverage deducted from his paycheck during his entire nine-year tenure with MAC. (Pet. App. 28a.) The plan (which is simply UNUM's policy) provides that written notice of a claim must be given to UNUM within 30 days of the onset of disability, if possible, or as soon as it is reasonably possible to do so. (Pet. App. 42a, 43a.) Written proof of claim is due, at the latest, 180 days after the onset of disability. (Pet. App. 43a, 5a.)

When Ward left MAC he had hoped that his health would improve enough to permit him to return to work, but his health deteriorated further and he was unable ever to work again. (Jt. App. 20, 21.) By December 1992, Ward's physicians informed him that his disabling medical condition was permanent. (Jt. App. 21.) In February 1993 he applied to California for state disability benefits, and his application was granted in late February or early March of 1993. (Jt. App. 19.)

Ward then notified MAC's Vice President for Administration, Dexana MacQuarrie, that he was disabled and inquired about benefits. (Jt. App. 19.) She advised him of his rights under COBRA to extend his health insurance coverage in light of his permanent disability. (Jt. App. 19.) In a letter to Ward dated March 30, 1993, MacQuarrie wrote: "Dear John: I was disappointed to hear that your condition is not improving

and is now considered a permanent disability." (Jt. App. 23.) The letter explained that, in order to qualify for extended health insurance coverage, Ward would have to obtain a determination from the Social Security Administration that he was disabled and would have to notify MAC of the determination. (Jt. App. 24.)

Ward did as instructed and by July 1993 he had obtained a determination from Social Security that he was permanently disabled as of May 10, 1992. (Jt. App. 21.) He forwarded a copy of the determination to Maria Bonney, a benefits administrator at MAC, in July 1993. (Jt. App. 19, 21.) On prior occasions Bonney had advised MAC employees who became disabled of the existence of MAC's own disability insurance program and of the need to file a claim with UNUM, and she had forwarded claim forms to several employee-claimants. However, she never advised Ward that he might seek benefits under MAC's plan. (Jt. App. 25, 26, 28.) Bonney testified that she simply did not think about whether Ward might be eligible for disability benefits under MAC's plan. (Jt. App. 28.) Vice President MacQuarrie's testimony was similar. When asked why she did not advise Ward about disability benefits under MAC's plan she explained: "It never occurred to me — the subject of [Long-Term Disability] never crossed my mind." (Jt. App. 22.)

In April 1994, while he was cleaning out a safe-deposit box, Ward found a booklet describing MAC's "Long Term Disability Income Benefits" policy. (Pet. App. 28a.) He immediately contacted Bonney at MAC to inquire why he was not covered by the plan. *Id.* She advised him that he was indeed covered and sent him an application for benefits. (Pet. App. 28a, 29a.) Ward completed the application and sent it back to MAC. (Pet. App. 29a.) MAC then completed the employer section and sent the application to UNUM on April 11, 1994. UNUM advised Ward on April 13, 1994, that it would not even review his claim because it was not submitted within the policy's time limits. (Pet. App. 29a.) Ward retained counsel, who requested on June 6, 1994, that UNUM review its denial of Ward's claim.

(Pet. App. 29a, 90a.) UNUM confirmed its denial of coverage only six days later. (Pet. App. 29a.)

Proceedings in the District Court.

Ward filed suit under ERISA in federal court to recover benefits under the policy. (Pet. App. 3a.) UNUM filed an answer on its behalf and on behalf of the MAC plan. (Pet. App. 4a.) Ward argued that under *Elfstrom v. New York Life*, 67 Cal.2d 503, 432 P.2d 731(1967), an employer who administers a group insurance plan for an insurer is the insurer's agent. Ward contended that since MAC was the plan administrator it was UNUM's agent under *Elfstrom*, and as a consequence Ward's notice to MAC in March 1993 that he was disabled constituted timely notice under the plan. (Pet. App. 7a.)

The district court held that the *Elfstrom* rule "related to" ERISA plans and was therefore preempted under Section 514(a), and was not saved from preemption by the saving clause, Section 514(b)(2)(a), 29 U.S.C. §§ 1144(a) and 1144(b)(2)(A) (Pet. App. 30a-31a.) The district court granted UNUM's motion for summary judgment, finding that Ward's claim, though sympathetic, was late, and UNUM therefore was not obligated to honor it. (Pet. App. 33a.)

The Ninth Circuit's Decision

Ward filed a timely appeal and the court of appeals reversed, holding that its decision in *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939 (9th Cir. 1998) (petition for cert. pending, No. 97-1367) required reversal and a remand for application of the California notice-prejudice rule. (Pet. App. 5a, 6a.) That rule prevents an insurer from avoiding liability on the basis of untimely notice or submission of proof unless the company can prove that it has sustained actual and substantial prejudice as a

result of the delay. *Cisneros,* 134 F.3d at 944.[1] The court instructed the district court to remand the case to the plan administrator to determine whether the plan had suffered prejudice because Ward's claim was late. (Pet. App. 6a.)

The Notice-Prejudice Rule

In *Cisneros* the court of appeals held that although the California notice-prejudice rule "related to" ERISA plans under Section 514(a) of ERISA, it was a law that regulated insurance and was therefore saved from preemption by ERISA's saving clause, Section 514(b)(2)(A). 134 F.3d at 944. Following *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740-743 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), the Ninth Circuit determined that the California notice-prejudice rule "effectively creates a mandatory contract term" and therefore regulates the insurance relationship between insured and insurer. 134 F.3d at 946. As in *Pilot Life* and *Metropolitan Life*, the court first determined that the notice-prejudice rule "regulated insurance" from a "common-sense" view, because it regulated the terms of insurance policies and was directed specifically at the insurance industry. 134 F.3d at 945.

Next, the court of appeals checked its conclusion against three criteria developed in the case law interpreting the phrase "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-1015. In *Metropolitan Life,* 471 U.S. at 743, this Court noted that *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), had "identified three criteria relevant to determining whether a particular practice falls within that Act's reference to the 'business of insurance'":

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[1] *See, e.g., Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal.App.4th 715, 760, 15 Cal.Rptr.2d 815, 845 (1993); *Clemmer v. Hartford Ins. Co.*, 22 Cal.3d 865, 881-882, 151 Cal.Rptr. 285, 293-95 (1978.)

> [F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry.

Pireno, 458 U.S. at 129.

The Ninth Circuit determined that the notice-prejudice rule satisfied the second and third *Pireno* factors because the rule was integral to the relationship between the policyholder and the insurer and applied only to the insurance industry. 134 F.3d at 946. The court further found that although the rule did spread costs, it did not appear to spread risk as that term had been discussed in *Pireno. Id.* Nevertheless, the court held that a state law could regulate insurance even if it did not spread risk. It read *Metropolitan Life*, *Pilot Life*, and *Pireno* as treating these three criteria as "relevant considerations or guideposts, not separate essential elements of a three-part test that must each be satisfied for a law to escape pre-emption." 134 F.3d at 946.[2]

The *Elfstrom* Rule

After determining that the judgment against Ward would be reversed and the case remanded, the court of appeals undertook an alternative analysis of the case based on Ward's argument that MAC was UNUM's agent under *Elfstrom*. (Pet.

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[2] In holding that a state law that did not spread risk could still regulate insurance the court of appeal disagreed with the Fifth Circuit, which had held that a law that did not spread risk did not qualify as a law that regulates insurance, and was necessarily preempted. *See Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105, 110 (5th Cir. 1993); *CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir. 1996), *cert. denied*, 519 U.S. 964 (1996); *Cisneros*, 134 F.3d at 946.

App. 7a.) The court determined that ERISA did not preempt *Elfstrom* in light of this Court's recent decisions in *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. 645 (1995), and *Cal. Div. Of Labor Enforcement v. Dillingham Construction Co.*, 117 S.Ct. 832 (1997). (Pet. App. 20a.) The Ninth Circuit reasoned that the *Elfstrom* rule was not preempted because it did not govern plan structure or create an alternative enforcement mechanism, and it meshed smoothly with fiduciary responsibilities imposed by ERISA. (Pet. App. 21a-22a.)

Although UNUM's policy contains a term disclaiming MAC's agency, the court of appeals held that the existence of an agency relationship was a question of fact, and was not controlled by how the policy characterized it.[3] (Pet. App. 14a, 15a.) In treating the existence of an agency relationship as a question of fact the court declined to apply *Elfstrom* literally. *Elfstrom* held that "the employer is the agent of the insurer in performing the duties of administering group insurance policies." 67 Cal.2d at 512, 432 P.2d at 737. A literal application of this rule would have required the court to find that MAC was UNUM's agent as a matter of law because it was the plan administrator. The court declined to make this finding, instead remanding to the district court for a factual determination of the nature of the relationship between UNUM and MAC. (Pet. App. 25a.)[4]

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[3] The court held that "whether a particular relationship is that of agency does not depend on what the parties call it, and the parties cannot, where the relationship is in fact one of agency, change its nature by declaring that it is not an agency . . . ." (Pet. App.15a, citing, *inter alia*, 2A C.J.S: Agency, § 7 (1972).)

[4] The court instructed that this issue need not be addressed on remand unless the notice-prejudice issue was resolved adversely to Ward. (Pet. App. 25a.)

SUMMARY OF ARGUMENT

I. The two questions presented in this case are independent. The judgment below must be affirmed if respondent Ward prevails on either one. The first issue is whether California's notice-prejudice rule, which Ward agrees "relates to" ERISA plans within the meaning of ERISA Section 514(a), is a state law that "regulates insurance" and is therefore saved from preemption by ERISA's saving clause, Section 514(b)(2)(A). In *Metropolitan Life* this Court recognized that, as a matter of common sense, laws that regulate the terms of insurance policies "regulate insurance." The notice-prejudice rule plainly does this because it alters the terms of insurance policies by overriding notice requirements unless the insurer can show prejudice, thereby changing the relative rights of insurer and insured under the contract. Indeed, this alteration of the terms of UNUM's policy is the gravamen of UNUM's complaint about application of the notice-prejudice rule.

UNUM asserts that the rule is derived from generally applicable doctrines, like the harmless error rule, and therefore that it is not directed toward the insurance industry. But the relevant California cases reveal a distinct and peculiar lineage for the notice-prejudice rule, which has always been exclusively a regulation of insurance contracts. UNUM cannot cite a single application of the notice-prejudice rule outside of the insurance context.

The notice-prejudice rule also satisfies the three factors used to determine application of the McCarran-Ferguson Act, which this Court employed in *Metropolitan Life* to buttress its common-sense analysis. UNUM argues that the notice-prejudice rule does not regulate insurance because it does not spread risk. UNUM is mistaken, but even if it were not, UNUM itself concedes that many state laws that do not spread risk have nonetheless been held by this Court to be laws regulating the business of insurance. Moreover, UNUM's premise that a state

insurance regulation must meet all three of the McCarran-Ferguson factors is wrong. This Court has expressly disavowed any application of the factors as a rigid three-part test; it has instead consistently applied the factors as mere guides or considerations to be weighed in the overall common-sense determination of whether a state law regulates insurance.

UNUM contends that, even if it falls within the saving clause, the notice-prejudice rule nevertheless conflicts with ERISA's exclusive civil enforcement scheme because it makes possible a late claim for benefits. But Ward's complaint invokes only the benefits remedy expressly provided by ERISA itself. While California's notice-prejudice rule alters the terms of UNUM's insurance policy and expands the circumstances where coverage is available, as the saving clause permits, it does not create a new remedy to recover those benefits.

Much of UNUM's brief is devoted to decrying the expense and disruption that may arise (1) from subjecting multi-state plans to differing state regulations and (2) from having a different regulatory regime apply to self-funded plans than to insured plans. But as this Court has frequently explained, Congress itself created both of those disuniformities in ERISA by preventing states from regulating self-funded plans while saving state insurance laws from preemption.

II. Ward assumes arguendo that the particular doctrine announced by the California Supreme Court in *Elfstrom v. New York Life,* under which an employer is deemed to be its insurer's agent as a matter of law, may well be preempted because it "relates to" ERISA plans. But that is irrelevant because the Ninth Circuit did not apply the *Elfstrom* rule in this case. Rather, by remanding the case for a factual inquiry into whether MAC functioned as UNUM's agent, the court below applied California's general principles of agency law. Those principles do not "relate to" ERISA plans and therefore are not preempted. State laws that indirectly affect plans by altering the market

incentives they face, or that prescribe the consequences of the organizational choices made by plans, do not "relate to" the plans. Here, California agency law sets forth the consequence for an insurer that chooses to involve another entity in administering its policy, but agency law does not bind the insurer to any particular arrangement for administration of its policy.

Mackey v. Lanier Collection Agency & Service, 486 U.S. 825 (1988), established that the meaning of "relates to" does not change depending upon which party is invoking the state law in question, or upon the type of lawsuit in which that rule is invoked. Because ERISA obviously would not preempt application of general agency principles to a plan in a garden-variety tort or contract suit brought by a plan creditor, such principles should not be deemed suddenly to "relate to" an ERISA plan simply because the suit is brought by a plan participant.

ARGUMENT

I. THE NOTICE-PREJUDICE RULE "REGULATES INSURANCE" AND IS THEREFORE SAVED FROM PREEMPTION BY THE ERISA SAVING CLAUSE.

Under the ERISA preemption clause, Section 514(a), ERISA's terms "supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." 29 U.S.C. § 1144(a). However, ERISA's insurance saving clause, Section 514(b)(2)(A), provides that "nothing in this sub-chapter shall be construed to exempt or relieve any person from any law of any state which regulates insurance." 29 U.S.C. §144(b)(2)(A). The saving clause thus "returns to the States the power to enforce those state laws that 'regulate insurance.'"

FMC Corp. v. Holliday, 498 U.S. 52, 58 (1990).[5] Because California's notice-prejudice rule "relates to" ERISA plans under Section 514(a), the only remaining issue under the first question presented is whether that rule "regulates insurance" under Section 514(b)(2)(A) and is therefore saved from preemption.

A. The Notice-Prejudice Rule Meets This Court's "Common Sense" Test As a Law That Regulates Insurance.

1. The notice-prejudice rule dictates the terms of insurance contracts and regulates the relationship between the insurer and its insured.

In its unanimous decision in *Metropolitan Life*, this Court established a common sense test for whether a state law "regulates insurance," 471 U.S. at 740, based on the "plain language of the saving clause," *id.* at 744, and concluded that state laws that regulate the content of insurance policies are within the scope of the saving clause. Thus in *Metropolitan Life* the Court held that "mandated benefit" statutes, which require that all insurance policies provide certain benefits, are state laws that regulate insurance. Specifically, the Court first observed, "To state the obvious, [the statute under review] regulates the terms of certain insurance contracts, and so seems to be saved from preemption by the saving clause as a law that 'regulates insurance.'" *Id.* at 740.

[5] The saving clause is, in turn, modified by the so-called "deemer" clause, which prevents a self-funded ERISA plan from being deemed an insurer or engaged in the business of insurance "for purposes of state laws 'purporting to regulate' insurance companies or insurance contracts." Section 514(b)(2)(B), 29 U.S.C. §1144(b)(2)(B) (Pet. App. 14a.) *See FMC Corp. v. Holliday*, 498 U.S. at 58. This case does not involve a self-funded ERISA plan, so there is no issue concerning application of the "deemer" clause.

The Court then explained that this "common-sense view of the matter" was "reinforced by the language of the subsequent subsection of ERISA, the 'deemer clause,'" which refers specifically to state laws "purporting to regulate . . . insurance contracts." 471 U.S. at 740.

> By exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause.

Id. at 741.

The ERISA saving clause preserves California's notice-prejudice rule because that rule, "by requiring the insurer to prove prejudice before enforcing proof-of-claim requirements. . . . effectively creates a mandatory contract term. The rule dictates the terms of the relationship between the insurer and insured, and consequently is integral to that relationship." *Cisneros*, 134 F.3d at 946.[6]

Indeed, UNUM concedes that the notice-prejudice rule regulates the terms of its disability insurance policy. UNUM's very complaint — which it italicizes — is that the notice-prejudice rule caused its insurance policy's "'written terms [to be] *altered*.'" (Pet. Br. 10, 32-33) (emphasis and brackets by petitioner). The alteration is plainly of considerable import to both the insured and the insurer because it can affect whether or

[6] As the Solicitor General points out, the only reason ERISA's preemption clause is even implicated in this case is because the notice-prejudice rule "relates to" ERISA plans insofar as it "in effect requires plans to include particular provisions (in this case, regarding the enforcement of claim filing deadlines) in their insurance contracts." Brief for the United States ("U.S. Br.") at 8-9.

not benefits are paid under the policy, which is of course the core concern of any insurance contract. *See United States Dept. of the Treasury v. Fabe*, 508 U.S. 491, 503-504 (1993). The notice-prejudice rule, "as a matter of common sense," therefore "'regulates] insurance.'" *Cisneros*, 134 F.3d at 945.

UNUM appears to argue that the ERISA saving clause does not protect the notice-prejudice rule because it is "merely a common-law rule," rather than a statute. (Pet. Br. at 23; 22-24) (urging that Congress meant to preserve only "'any law *enacted* by any State for the purpose of regulating'" insurance)(emphasis by petitioner). This distinction is foreclosed by the statute itself. ERISA defines the state insurance regulations it preserves as "all laws, decisions, rules, regulations, or other state action, having the effect of law, of any State." 29 U.S.C. §§ 1144(c)(1) and (2). Common-law rules developed by state courts, like California's notice-prejudice rule, therefore qualify under ERISA as "state law" and are saved from preemption if they "regulate insurance." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48 n.1 (1987).

UNUM also argues that because the notice-prejudice rule, unlike a mandated benefit statute, does not define the scope of coverage in the insurance contract, it affects only policy administration and therefore is not "substantive." (Pet. Br. 28.) Assuming *arguendo* that the rule relates purely to claims "administration," this label is a UNUM creation found nowhere in ERISA, and it therefore has no bearing on the scope of the ERISA saving clause.[7] In *Metropolitan Life* this Court included

[7] The saving clause makes no distinction between state laws that regulate "substantive" terms and those that regulate claims processing or administration. A state law that prohibited insurance companies from denying medical claims as "medically unnecessary" unless that judgment was made by a physician, would relate to policy administration, but it would surely also be a state law that "regulated insurance" and was therefore saved from preemption.

in its description of laws that "regulate insurance" laws that regulate such claims administration practices as "grace periods" for complying with insurance policy deadlines. 471 U.S. at 728 n. 2. This is consistent with the Court's observation in *SEC v. National Securities, Inc.*, 393 U.S. 453, 459 (1969), upon which the Court relied in *Metropolitan Life*, that the entire purpose of the McCarran-Ferguson Act[8] was "to assure that the activities of insurance companies in dealing with their policyholders would remain subject to state regulation."

> "The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement — these were the core of the 'business of insurance.'"

Metropolitan Life, 471 U.S. at 743-44 (quoting *National Securities*, 393 U.S. at 460).

This Court has consistently refused "to read limitations into" the ERISA saving clause beyond those imposed by Congress itself. *Metropolitan Life*, 471 U.S. at 741. In that case the insurer and its *amici* argued that the saving clause should include only "traditional insurance laws," such as laws regulating sales practices, but should not protect "laws that regulate the substantive terms of insurance contracts." *Id.* The Court rejected that proposed amendment of the saving clause, holding that "[i]f a state law 'regulates insurance,' . . . it is not preempted. Nothing in the language, structure, or legislative history of the Act supports a more narrow reading of the clause." *Id.* at 746.

[8] The McCarran-Ferguson Act contains language, at 15 U.S.C. § 1012(b), that parallels the ERISA saving clause, and which serves the same federal policy — permitting the states to regulate the insurance business. *Metropolitan Life*, 471 U.S. at 744 n.21.

There is no reason, however, to accept UNUM's characterization of the notice-prejudice rule as "administrative" rather than "substantive." The rule does not impose any obligation on the insurer about how to process claims. Instead, it changes the relative rights of the parties to the insurance contract by limiting the circumstances that permit the insurer to deny coverage. And this substantive alteration of the policy is, after all, the gravamen of UNUM's objection to the notice-prejudice rule. (See Pet. Br. 11, 32-33.)

2. The notice-prejudice rule is directed expressly and exclusively at insurance companies.

"A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). In *Cisneros*, the court below held that California's notice-prejudice rule met this requirement because the "rule is directed specifically at the insurance industry and is applicable only to insurance contracts." 134 F.3d at 945.

UNUM never contested this proposition in the court below.[9] Nevertheless, UNUM and its *amici* now argue that the notice-prejudice rule cannot be saved from preemption because it is "merely a common law rule of general application" which is not directed at the insurance industry. (Pet. Br. 23.) UNUM did not raise this argument in the Ninth Circuit nor in its petition for certiorari. Rather, as the Solicitor General notes, UNUM first presented this question about the notice-prejudice rule in its reply

[9] UNUM did not brief the application of the notice-prejudice rule in the Ninth Circuit. Rather, the sole issue in the case was whether MAC was UNUM's agent. UNUM's petition for rehearing and suggestion for rehearing en banc did not address the court's application of the notice-prejudice rule.

brief at the certiorari stage. U.S. Br. at 11. Therefore, it is a serious question whether this issue is properly before this Court and whether the belated insertion of this question by petitioner thwarts the proper functioning of this Court's certiorari process. *See Yee v. City of Escondido*, 503 U.S. 519, 533 (1992).

Assuming *arguendo* that this issue is "fairly included" in the questions presented in the petition, Sup.Ct.R. 14.1(a), petitioner's new argument is nevertheless wholly without merit. UNUM attempts to equate the California notice-prejudice rule with the Mississippi law of bad faith at issue in *Pilot Life*, but the comparison does not work in UNUM's favor. In *Pilot Life*, this Court traced the origins of plaintiff Dedeaux's claim for punitive damages for tortious breach of contract. Mississippi's Supreme Court had first recognized the availability of such relief in a 1915 contract action brought against a physician. *Pilot Life*, 481 U.S. at 49. Other early cases involved claims against a finance company for loss of cabled funds and against an individual for the destruction of a fence. *Id.* The generic doctrine allowing recovery of punitive damages was not applied against a defendant insurance company until 1977 — more than sixty years after the doctrine first arose. *Id.* Accordingly, this Court concluded in *Pilot Life* that the Mississippi doctrine of tortious breach was not "specifically directed toward th[e] [insurance] industry," but was generally applicable: "*Any* breach of contract, and not merely a breach of an insurance contract, may lead to liability for punitive damages under Mississippi law." 481 U.S. at 50 (emphasis added).[10]

[10] Indeed, even though employment of the doctrine in insurance litigation is now common, it is still expressed in generic terms applicable to any defendant in any industry, occupation, or other context. *See Pilot Life*, 481 U.S. at 48 (noting that plaintiff Dedeaux pleaded and described his own claim as a generic one for "tortious breach of contract" under "the Mississippi law of bad faith").

The same cannot be said about California's notice-prejudice rule. While UNUM and its *amici* are able to find California cases in which the English words "notice" and "prejudice" appear on the same page of the opinion, they cannot identify a single application of the notice-prejudice rule outside of the insurance context. (See cases cited at Pet. Br. 28; Brief *Amicus Curiae* of Cal. Ass'n. of Health & Life Insurers at 4-5.) Nor is respondent Ward — or for that matter, the Solicitor General — aware of any such case. (U.S. Br. at 12.) That is hardly surprising, given that the rule by its terms applies exclusively to "insurance companies" and concerns only prejudice to an "insurer" resulting from untimely notice from an "insured."[11]

UNUM and its *amici* offer a fictional bloodline for the notice-prejudice rule — a genealogy untainted by analysis of *any* of the California cases that actually developed the rule.[12] The relevant cases reveal a distinct and peculiar lineage for the notice-prejudice rule, which was formulated in decisions arising

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[11] *See, e.g., Shell Oil v. Winterthur Swiss Ins. Co.*, 12 Cal.App. 4th 715, 760 (1993) ("California law is settled that a defense based on an insured's failure to give timely notice requires the insurer to prove that it suffered substantial prejudice."); *Pacific Employer's Ins. Co. v. Superior Court*, 221 Cal.App.3d 1348, 1356, 270 Cal.Rptr. 779 (1990) ("California's notice-prejudice rule operates to bar insurance companies from disavowing coverage on the basis of lack of timely notice unless the insurance company can show actual prejudice from the delay.").

[12] UNUM claims that California's notice-prejudice rule is derived from two generally applicable common law doctrines: a duty of cooperation imposed on all parties to a contract, and a rule that prejudice must be shown before the failure to perform a contractual obligation or give a required notice will work a forfeiture. (Pet. Br. 27-28.) UNUM's amicus adds the theory that the notice-prejudice rule is merely a form of the general harmless error rule. Brief *Amicus Curiae* of Cal. Ass'n. of Health & Life Insurers at 5.

under several versions of a California statute that permitted an injured person who obtains a judgment against an insured person to bring an action against the insurer "on the policy" to satisfy the judgment.[13]

Far from being, as UNUM and its *amici* claim, merely a manifestation of general common-law principles about duties of cooperation by contracting parties, lack of prejudice, or harmless error, the original formulation of California's rule about notice in suits "on the policy" in fact rejected these principles and favored the insurance company by mandating strict enforcement of notice requirements as material terms of insurance contracts.[14]

The California Supreme Court spoke to the issue for the first time, albeit indirectly, in *Hynding v. Home Acc. Ins. Co.*, 214 Cal. 743, 7 P.2d 999 (1932). *Hynding* considered whether an insurer could assert its insured's failure to cooperate with it (by failing to attend the trial) as a defense in an action brought "on the policy" by the injured party against the insurer to satisfy a judgment against the insured. The court held that the insurer could indeed assert the insured's breach as a defense, provided that the insurer proved it was substantially prejudiced by the breach. 214 Cal. at 752, 7 P.2d at 1002. The only authorities cited by the court for this prejudice requirement were other

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[13] Cal. Stats. Of 1919, p. 776 (repealed), now Cal. Ins. Code § 11580, subd. (B)(2).

[14] The earliest California case Ward has been able to locate that addressed the effect of the insured's failure to comply with the notice provision in an insurance policy is *Aronson v. Frankfurt Acc. & Plate Glass Ins. Co.*, 9 Cal. App. 473, 99 P. 537 (1908), which held that the insured's failure to give timely notice barred coverage. *See also Los Angeles Athletic Club v. United States Fid. & Guar. Co.*, 41 Cal. App. 439, 183 P. 174 (1919) (court rejects plaintiff's claim that a minor breach of the policy should not bar coverage, holding instead that the condition requiring prompt notice was a material term of the contract).

insurance cases. *Id.* The notice-prejudice rule continued to develop thereafter as a distinctive regulation tailored to insurance policies.

Despite its statement regarding the need for the insurer to establish prejudice, *Hynding* did not change the law regarding a failure of notice. In 1935, the California Supreme Court held that an insured's failure to give timely notice prevented the insurer from conducting a prompt investigation of the claim and was presumed prejudicial. *Purefoy v. Pacific Auto. Indem. Exch.*, 5 Cal.2d 81, 53 P.2d 155 (1935). The lower courts read *Purefoy* to establish a conclusive presumption that the insured's failure to give timely notice was prejudicial.[15]

In *Abrams v. Am. Fid. & Cas. Co.*, 32 Cal.2d 233, 195 P.2d 797 (1948), the California Supreme Court cut back on *Purefoy* by holding that the insured could rebut the presumption with evidence that the insurer had not actually sustained prejudice. 32 Cal.2d at 238-239. Most cases thereafter held that the insured bore the burden of proving that the insurer had not sustained prejudice.[16]

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[15] *See, e.g., Distributors Packing Co. v. Pac. Indem. Co.*, 21 Cal. App. 2d 205, 70 P.2d 253 (1937); *Margellini v. Pacific Auto. Ins. Co.* 33 Cal.App.2d 93, 91 P.2d 136 (1939); *Burbank v. Nat. Cas. Co.*, 43 Cal.App.2d 773, 111 P.2d 740 (1941); *Brown Materials Co., LTD v. Pac. Auto. Ins. Co.*, 52 Cal.App.2d 760, 127 P.2d 51 (1942); *Arthur v. London Guar. & Acc. Co.*, 78 Cal. App.2d 198, 177 P.2d 625 (1947).

[16] *See, e.g., Reed v. Pac. Indem. Co.*, 101 Cal.App.2d 151, 225 P.2d 255 (1951)(burden on insured); *Artukovich v. St. Paul-Mercury Indem. Co., Inc.*, 150 Cal.App.2d 312, 310 P.2d 461 (1957)(same); *Security Ins. Co. v. Snyder-Lynch Motors, Inc.*, 183 Cal.App. 2d 574, 7 Cal.Rptr. 28 (1960)(same). *But see Joyce v. United Ins. Co. of America.*, 202 Cal.App.2d 654, 21 Cal.Rptr. 361 (1962)(untimely notice did not defeat claim where insurer failed to produce evidence of prejudice).

California's notice-prejudice rule finally took its present form (but not yet its familiar name) in 1963 in *Campbell v. Allstate Ins. Co.*, 60 Cal.2d 303, 32 Cal.Rptr. 827 (1963). *Campbell*, like *Hynding* and *Abrams*, was an action against the insurer to satisfy a judgment against its insured. It reaffirmed the requirement imposed by *Hynding* that the insurer could not assert its insured's breach of a condition imposed by the policy as a defense unless it demonstrated that the breach caused it to sustain substantial prejudice. 60 Cal.2d at 305-306. The court also held that the insurer bore the burden of proving it had sustained prejudice, and that prejudice could no longer be presumed. *Id.* at 306-307.[17]

The term "notice-prejudice rule" was first used in a depublished California decision in 1988,[18] and the first published decision to use the term was *Industrial Indem. v. Superior Court*, 224 Cal.App.3d 828, 275 Cal.Rptr. 218 (1990), which refused to apply the rule to a "claims made" insurance policy. The majority position among the California courts is that the rule is only applicable to "occurrence"-type policies, and not to so-called "claims-made" policies.[19] Thus, far from being a generally

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[17] The rule was refined in *Billington v. Interins. Exch. Of So. Cal.*, 71 Cal.2d 728, 79 Cal.Rptr. 326 (1969), where the court held that, in order for an insurer to prove it has been prejudiced by the insured's lack of cooperation, it must establish that if the clause had not been breached there was a substantial likelihood that the trier of fact in the underlying suit against the insured would have found in the insured's favor.

[18] *Village Escrow Co., Inc. v. Nat. Union Fire Ins. Co.*, 248 Cal.Rptr. 687 (1988), review denied and ordered withdrawn from publication in the Official Reports, Oct. 13, 1988.

[19] There is a split of authority in California regarding the application of the rule to "claims-made-and-reported" types of policies, as opposed to "occurrence" policies. Compare *Pacific Employer's Ins. Co. v. Superior Court*, 221 Cal.App.3d at 1358-1361

applicable common-law rule like Mississippi's punitive damages doctrine, the notice-prejudice rule is not even universally applied within its own constricted field of insurance regulation.

There is one further important difference between this case and *Pilot Life*. This Court found the connection between Mississippi's punitive damages rules and "the insurer-insured relationship" to be "attenuated at best." 481 U.S. at 50-51. That common law doctrine "does not define the terms of the relationship between the insurer and the insured; it declares only that, whatever terms have been agreed upon," a breach of that contract "may in certain circumstances allow the policyholder to obtain punitive damages." *Id.* at 51. In contrast, California's notice-prejudice rule, as demonstrated above, overrides an insurance contract's deadlines and thereby alters the policy's terms and rearranges the rights of insurer and insured under the contract.

This history of the California notice-prejudice rule demonstrates that UNUM's claim that the rule is a generally applicable common-law contract rule is a sham. The contrast between this case and the Mississippi law of tortious breach of contract at issue in *Pilot Life* could not be more stark. The notice-prejudice rule has, from its origins 90 years ago, always been a regulation of insurance contracts *only*, and originally it was the very opposite of a "harmless error" or "no prejudice" rule. But even were we to posit *arguendo* that the contemporary

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(holding that the notice-prejudice rule does not apply to "claims-made" policies) and *Slater v. Lawyer's Mut. Ins. Co.*, 227 Cal.App.3d 1415, 1422-1424, 278 Cal.Rptr. 479 (1991)(same); with *Northwestern Title Security Co. v. Flack*, 6 Cal.App.3d 134, 143-144, 85 Cal.Rptr. 693 (Cal. App. 1970) (rejecting distinction for purposes of operation of the rule). The policy at issue here is not a "claims-made" policy, and UNUM has not argued in this Court or below that the notice-prejudice rule should not apply here for any reason other than ERISA preemption.

version of the rule, which no longer presumes prejudice and now puts the burden of proving prejudice on the insurer, could be seen as resonating with harmless error rules found elsewhere in the common law, the result in this case would not change.

Pilot Life remarked that the "roots" of the Mississippi doctrine of bad faith were "firmly planted in the general principles of Mississippi tort and contract law." 481 U.S. at 50. UNUM seeks to extrapolate from this a broad principle that no common law rule, even one directed exclusively at the insurance industry, can qualify as an insurance regulation under the saving clause unless it is truly *sui generis*. But petitioner reads far too much into the Court's turn of phrase, which merely pointed out the general applicability of the Mississippi doctrine.

Surely a state law specifically directed at insurance does not lose its protected status under the ERISA saving clause simply because its animating principles might be similar to the principles underlying other rules found elsewhere in the expansive corpus of the common law. The law is, after all, a seamless web, and its various principles enrich and inform each other as the law evolves. It would be bizarre if the principles underlying one body of law, such as insurance regulation, were in fact wholly unique and entirely unrelated to any other rules anywhere else in the common law — as if the law's categories had separated like the Earth's continents long ago, leaving insurance regulation as some quirky collection of evolutionary oddities and dead-ends, the legal equivalent of Australia's duckbilled platypus and marsupials. Yet that is the understanding of the common law that UNUM asks this Court to embrace.

UNUM's approach is simply an ill-disguised attempt to read into the saving clause restrictions that Congress did not include. This argument proves too much, for under it even recognized forms of state insurance regulation, such as laws forbidding false and deceptive insurance sales practices, would

be considered mere manifestations of the generally applicable common law tort rules of fraud, and would therefore be preempted. Yet in *FTC v. Nat'l Casualty Co.*, 357 U.S. 560, 562 & n. 2 (1958), this Court held that state laws prohibiting false, misleading and deceptive insurance sales practices were indeed laws "regulating the business of insurance." UNUM's radically reductive approach would empty the saving clause of meaning and convert ERISA into a juggernaut of destruction of state insurance regulations that Congress manifestly intended to preserve.

B. The McCarran-Ferguson Act Factors Confirm That The California Notice-Prejudice Rule Is Insurance Regulation That Is Saved From Preemption.

In *Metropolitan Life* this Court found that its "common-sense" determination of whether a state law regulated insurance for purposes of the ERISA saving clause was supported by "the traditional understanding of insurance regulation." 471 U.S. at 744. That understanding is to be found by reference to cases interpreting the scope of the McCarran-Ferguson Act — in particular, by reference to the three factors summarized in *Pireno*, 458 U.S. at 129. *See* page 5, *supra*.

But while often illuminating, consideration of these factors has not been held by this Court to be an essential part of its analysis under the ERISA saving clause if the common sense inquiry is sufficient to render an answer. Thus in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), which contains this Court's most recent discussion of the saving clause, the Court did not even discuss the McCarran-Ferguson Act factors in concluding that Pennsylvania's anti-subrogation law regulated insurance. Instead, the Court relied exclusively on the common sense analysis set forth in *Metropolitan Life*: Does it regulate insurance contracts, and is it directed only at the insurance industry?

> There is no dispute that the Pennsylvania law falls within ERISA's insurance savings clause. . . . Section 1720 directly controls the terms of insurance contracts by invalidating any subrogation provisions they contain. It does not merely have an impact on the insurance industry; it is aimed at it.

498 U.S. at 60-61.[20]

That same common-sense analysis is more than sufficient to decide this case without separate consideration of the McCarran-Ferguson Act factors, because the Court's conclusions in *FMC* apply with equal force to California's notice-prejudice rule. As demonstrated above, (1) the rule regulates the relationship between insurer and insured by overriding any policy terms that permit denial of benefits for non-prejudicial lapses in timely notice; and (2) the rule applies exclusively to insurance contracts and the insurance industry.

In any event, consideration of the McCarran-Ferguson factors only confirms this conclusion. In *Cisneros* the court of appeals held that the notice-prejudice rule easily met two of the McCarran-Ferguson factors, which overlap with the common-sense test discussed above. Specifically, the court of appeals held that the rule regulates "an integral part of the policy relationship between the insurer and the insured" and that it is "limited to entities within the insurance industry." 134 F.3d at 946. Those conclusions are sound and not subject to serious

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[20] The portion of the *Metropolitan Life* opinion cited by the Court in *FMC*, 471 U.S. at 740-41, discussed the common-sense view that the statute regulated insurance because it regulated the content of insurance contracts, and the way in which ERISA's "deemer clause" reinforced that conclusion. *FMC* neither referred to nor relied upon the portion of the *Metropolitan Life* opinion that discussed the McCarran-Ferguson Act factors.

question. The only real dispute is over the remaining McCarran-Ferguson Act factor: whether the notice-prejudice rule "has the effect of transferring or spreading a policy-holder's risk." *Metropolitan Life*, 471 U.S. at 743.

1. The notice-prejudice rule can be understood as spreading risk within the meaning of the first McCarran-Ferguson Act factor.

In *Cisneros* the Ninth Circuit concluded that, although the notice-prejudice rule "does shift the risk of lost coverage as a result of late submission of proof," it does not "alter the allocation of risk for which the parties initially contracted" — that is, the risk of disability. 134 F.3d at 946. It therefore held that the rule does not satisfy the McCarran-Ferguson "risk spreading" criterion, which it believed refers only to the specific risk of injury for which the insurer agreed in the policy to compensate the insured. *Id.* at 945-46. As the Solicitor General points out, the line the court of appeals tried to draw is not without support in the decisions of the lower federal courts, but in the final analysis it is unsatisfactory. U.S. Br. at 13-14 & n.6.

In particular, this purported distinction between different risks is in tension with this Court's decision in *United States Dept. of the Treasury v. Fabe*, 508 U.S. 491 (1993). *Fabe* demonstrates that a law can be deemed to spread risk if it is directed to ensuring that the insurance contract will be performed and that benefits will be provided, even if that law does not itself address the question of benefits or the terms of coverage under the policy. *Fabe* held that an Ohio statute establishing the priority of creditor claims against insurance companies in liquidation regulated the "business of insurance" to the extent that it operated to protect policyholders by giving them a preference. The Court rejected the argument that the statute did not spread risk, because without that preference the insurance policies would never be performed, no benefits would be paid, and hence the contracted-for risk would never be spread:

> There can be no doubt that the actual performance of an insurance contract falls within the "business of insurance" as we understood that phrase in *Pireno* . . . . Without performance of the terms of an insurance policy, there is no risk transfer at all.

508 U.S. at 503-504.

The notice-prejudice rule operates in much the same way the Ohio statute did in *Fabe*, and under its approach can be said to spread risk. Neither law increases an insured's coverage, but both operate to ensure the policy will be performed to the insured's benefit in circumstances where, in the absence of the rule or preference, there would be no performance and hence no risk-spreading.

Furthermore, as the Solicitor General points out, "insofar as the notice-prejudice rule shifts the risk of late notice and stale evidence from the insured to the insurance company in some instances, it has the effect of raising premiums and spreading risk among policyholders." U.S. Br. at 14. Indeed, UNUM itself has taken this same position on risk-spreading. In *Cisneros*, UNUM argued that the Pennsylvania anti-subrogation statute at issue in *FMC v. Holliday* did, in fact, spread risk, because it would have forced benefit providers "to calculate benefit levels differently" as a result of their inability to recoup the costs of benefit payments made to participants and beneficiaries. (Reply Br. of Petitioner UNUM to Brief In Opposition in No. 97-1867 at 6 n.4). "As such, the law would clearly impact 'the risks of injury that the insurance company will bear for the insured.'" (*Id.*) (citation omitted). UNUM's argument is that the statute raised the benefit providers' costs, which would ultimately either be passed on in the form of higher premiums or be offset by lower benefit levels. That is the same argument made by the Solicitor General with respect to the notice-prejudice rule. Ward concurs with the Solicitor General and with UNUM on this point.

The Court need not resolve in this case any tension that may exist between the discussion of risk spreading in *Pireno* and its decisions in *Fabe* and *FMC*, because there simply is no requirement that a state law spread risk in order to be characterized as "regulating insurance" under the saving clause.

2. A state law may "regulate insurance" within the meaning of the ERISA saving clause even if it does not spread the particular kind of risk addressed by the McCarran-Ferguson Act factor.

This Court has observed that risk-spreading, one of the McCarran-Ferguson factors, is an "indispensable" element of an insurance contract. *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211-12 (1979). From this unremarkable proposition UNUM concocts the remarkable non-sequitur that no law qualifies as a regulation of insurance *unless* it directly spreads risk itself. (Pet. Br. 10, 23-26.) UNUM contends that no state law is saved from preemption under ERISA unless it meets *all three* of the McCarran-Ferguson Act factors and, in particular, that "the failure to spread risk, by itself, places the notice-prejudice rule far outside the saving clause." (Pet. Br. 23.)[21]

Not so. Ever since this Court first enumerated those three factors it has consistently disavowed any use of them as a

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[21] In making this argument that a state law that does not spread risk cannot regulate insurance, the insurance industry has turned 180 degrees from its position in *Metropolitan Life*. There, it argued that a mandated-benefit law, the epitome of a risk-spreading law, did not regulate insurance. Brief *Amicus Curiae* of the American Council of Health Insurers in No. 84-325, at 19, 20; Brief of Appellant Metropolitan Life Ins. Co. in No. 84-325, at 35-37. Now it argues that *unless* a law is a mandated benefit law, it cannot be said to regulate insurance.

mandatory three-part test, either under the McCarran-Ferguson Act itself or with respect to ERISA preemption. In *Pireno* this Court explicitly cautioned that "[n]one of these criteria is necessarily determinative in itself." 458 U.S. at 129. UNUM dismisses this statement as "ambiguous dictum" (Pet. Br. 24), but there is nothing ambiguous about it and the Court's use of the factors after *Pireno* has been fully consistent with this statement. In *Pilot Life* the Court referred to the three factors as "guide[s] and "considerations [to be] weighed." 481 U.S. at 48.[22] In *Metropolitan Life*, where the factors were first applied to illuminate the ERISA saving clause, the Court described them not as three independent *sine qua nons* of insurance regulation, but merely as "three criteria relevant to determining whether a particular practice falls within . . . the 'business of insurance.'" 471 U.S. at 743. The Ninth Circuit was therefore entirely consistent with this Court's own approach when it held that the McCarran-Ferguson factors "are simply relevant considerations or guideposts, not separate essential elements of a three-part test that must be satisfied for a law to escape preemption." *Cisneros*, 134 F.3d at 946.[23]

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[22] In *Pilot Life*, on which UNUM places great weight, if the failure to spread risk had indeed been dispositive in and of itself, there would have been no need for the Court to address the other two factors once the Court had determined that the law in question did not spread risk. 481 U.S. at 50. Yet the Court did so. *Id.* at 50-51.

[23] Two other circuits have likewise adhered to this Court's approach. *See O'Connor v. UNUM Life Ins. Co.*, 146 F.3d 959, 963 (D.C. Cir. 1998) ("none of the factors in the test is by itself determinative of what constitutes the business of insurance"); *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 940 (6th Cir. 1997) ("These criteria must be considered in combination, and, standing alone, no single one is dispositive."). The only court to have taken the rigid approach urged by UNUM is the Fifth Circuit. *See CIGNA Healthplan v. Louisiana*, 82 F.3d 642, 650 (5th Cir.) ("if a statute fails . . . to satisfy any one element of the . . . test, then the statute is not exempt from preemption"), *cert. denied*, 519 U.S. 964 (1996).

Even on its own terms, UNUM's crabbed definition of the regulation of insurance makes no sense. To accept that risk-spreading is an "indispensable characteristic of insurance," *Royal Drug*, 440 U.S. at 211-12, is not to say that it is the *only* characteristic of insurance. While the business of insurance may be, as a commercial matter from the insurance company's perspective, basically the spreading of risks, there is no reason that a law regulating the insurance business must spread risk. This Court has accordingly recognized that the "broad category of laws enacted 'for the purpose of *regulating* the business of insurance' . . . necessarily encompasses more than just the 'business of insurance.'" *Fabe*, 508 U.S. at 505 (emphasis added).

For example, state laws "aimed at protecting or regulating" the relationship between the insurance company and the insured, whether "directly or indirectly, are laws regulating the 'business of insurance.'" *SEC v. National Securities*, 393 U.S. at 460.[24] In *Metropolitan Life*, this Court included in its description of the many facets of state insurance regulation several types of laws that do not spread risk in the way UNUM uses the term. These included laws "governing solvency or the qualification of management" [of insurers], laws regulating "claims practices or rates," and laws requiring insurance policies to provide grace periods and conversion privileges. 471 U.S. at 728 n.2. Furthermore, this Court held in *Federal Trade Commission v. Nat. Cas. Co.*, 357 U.S. at 564, that a state law that regulated deceptive insurance advertising qualified as a state law "enacted for the purpose of regulating the business of insurance" under the McCarran-Ferguson Act.

All of these laws would be preempted under UNUM's unduly narrow definition of insurance regulation. UNUM, however, realizing that its argument is without support in logic

[24] California's notice-prejudice rule falls into this category, as demonstrated above.

or precedent, ultimately concedes the point at pages 25-26 of its brief, where it acknowledges that many state laws that do not spread risk have nonetheless been held to "regulate insurance," including laws that govern the "selling and advertising of policies and the licencing of insurers and their agents."[25]

[25] Oddly, two of UNUM's *amici* here, the American Council of Life Insurers and the Health Insurance Industry of America, who in this case endorse UNUM's limited view of what constitutes insurance regulation, have advanced an incompatible view in another case argued this term, *Forsythe v. Humana*, No. 97-303. In their amicus brief filed in that case, these insurance industry trade associations urged the Court to construe the McCarran-Ferguson Act to preserve the "carefully constructed system of individual state regulation designed to protect insurance policyholders not only from misleading insurer misconduct, but also from, among other things, risks to the solidity of insurers and to an adequate and healthy insurance market." Brief of American Council of Life Insurers, 1998 WL 457677*4. Yet, state insurance regulations of this type do not spread risk. In fact, the very Nevada statute at issue in *Forsythe*, which prescribes the penalties available to a party defrauded by an insurer, does not spread risk. If the test proposed by UNUM and its *amici* here were applied in *Forsythe*, it would wholly undercut the argument of petitioner Humana, on behalf of itself and the entire insurance industry, that RICO cannot be applied to insurers without "impairing" the Nevada statute and similar laws in other states. Another insurance industry *amicus* in *Forsythe*, the Consumer Credit Insurance Assoc. of America, helpfully compiled in its brief a 50-state survey of state laws that it said regulate insurance, but that would be invalidated or impaired if the Court affirmed the judgment against petitioner Humana in *Forsythe*. Most of those laws do not spread risk, and therefore would not qualify as "state laws enacted for the purpose of regulating the business of insurance" under the test proposed by UNUM and its *amici* here.

C. The Notice-Prejudice Rule Does Not Conflict With Any Aspect of ERISA or Any Other Federal Law.

UNUM contends that, even if the notice-prejudice rule falls within the saving clause, it is nevertheless preempted because it conflicts with various parts of ERISA, the ERISA regulations promulgated by the Department of Labor, and the McCarran-Ferguson Act. UNUM's argument is wrong on all counts.

UNUM first argues that the rule conflicts with ERISA's exclusive civil enforcement remedies because it "furnish[es] a state remedy under which benefits are not 'confined to the terms of the plan as written.'" (Pet. Br. 33.) This argument is grounded on the mistaken premise that a claim that conflicts with the terms of a plan cannot be a claim for benefits under ERISA, 29 U.S.C. § 1132(a), and therefore instead must be a forbidden state cause of action for failure to pay benefits. (Pet. Br. 9, 16, 32-33.) *Metropolitan Life* teaches otherwise. There, the Court sustained the enforcement of a statute requiring insurance policies to provide mental health benefits, *even though the policy itself did not provide the required benefits*. 471 U.S. at 734.[26] Similarly, *FMC Corp.* allowed the application of a state law forbidding subrogation claims even if the policy in question expressly provided for subrogation. 498 U.S. at 60-62.

It simply makes no sense to argue, as UNUM does, that although ERISA permits a state to alter the terms of an insurance contract to provide certain benefits, ERISA nevertheless forbids

[26] *Metropolitan Life* provided another example of a state insurance regulation that would not be preempted by ERISA even when it altered contract terms: a law that would "require that coverage for dependents *continue beyond any contractually imposed age limitation* when the dependent is incapable of self-sustaining employment because of mental or physical handicap." 471 U.S. at 729 (emphasis added).

the policyholder from seeking benefits under the altered policy. Ward's complaint expressly (and exclusively) invoked 29 U.S.C. § 1132 and sought only the recovery of benefits pursuant to ERISA. Pet. App. 77a-80a. The fact that state law, as ERISA permits, changed the terms of UNUM's policy to expand the benefits provided does not mean that the law created a new remedy.[27]

UNUM next contends (Pet. Br. 34-35) that the notice-prejudice rule conflicts with the rules for claims processing set forth in Section 503 of ERISA, 29 U.S.C. §1133, and with the regulations promulgated by the Department of Labor under that section, 29 C.F.R. § 2560.503-1(b), (c) & (d). (Pet. App. 105a-107a). There is no conflict. The notice-prejudice rule defines the circumstances when a claim can be denied based on late notice by the insured. The statutory provision UNUM cites, Section 503, deals with the claimant's rights *after* a claim has been denied. The regulations UNUM points to specify the minimum requirements for a reasonable claims procedure that all plans must meet. 29 C.F.R. § 2560.503-1(a). None of these provisions addresses *when* notice must be given. The United States itself perceives no conflict between these provisions and the notice-prejudice rule. U.S. Br. at 19 n.9.

Finally, UNUM complains that applying the notice-prejudice rule to insurance contracts bought by ERISA plans, but not to self-funded plans exempted by ERISA's "deemer clause,"

[27] In a similar vein, UNUM argues that application of the notice-prejudice rule, contrary to a plan's express establishment of notice deadlines, conflicts with the ERISA requirement that plan fiduciaries follow the written terms of the plan and pay benefits only in accord with those terms. (Pet. Br. 9, 14, 32-33.) *See* 29 U.S.C. §§1104(a)(1)(D), 1132(a)(1)(B). This argument is frivolous. Those ERISA provisions cannot be read to require fiduciaries to follow a plan's terms in contravention of applicable state or federal law that imposes different obligations.

would subvert an alleged congressional program of "'nationally uniform administration' of all plans, self-funded and insured alike." Pet Br. 9. *See id.* at 14-15, 21. This argument was unanimously rejected by the Court more than a decade ago:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.

Metropolitan Life, 471 U.S. at 747. *See also FMC Corp.*, 498 U.S. at 64 ("Our interpretation of the deemer clause makes clear that if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it.").[28]

Undeterred, UNUM takes its "disuniformity" harangue to the next level, arguing that, if state laws like the notice-prejudice rule are saved from ERISA preemption, "[c]haos" is "certain to follow, with plan administration for interstate employers once again becoming a Byzantine maze" of conflicting regulations. (Pet. Br. 12; 31, 46-49.) This argument was also unanimously rejected in *Metropolitan Life*:

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[28] Petitioner argues that the deemer clause would bar application of the notice-prejudice rule in cases where a self-funded plan hired an insurance company not to insure, but only to administer, the plan. (Pet. Br. 36-37.) Perhaps so, but the plan at issue here, MAC's plan, is an insured plan and UNUM is the plan insurer. The deemer clause therefore has no direct application in this case, although its existence in ERISA does buttress Ward's reading of the saving clause, as explained in Part I.A. above.

> We also are aware that [a different] construction of [ERISA] would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation. Arguments as to the wisdom of these policy choices must be directed at Congress.

471 U.S. at 747.

Refusing to take Congress (and this Court) at its word, UNUM perseveres, protesting that this "dysfunction" cannot be viewed simply as an inevitable result of Congress' desire to save state insurance regulation. (Pet. Br. 31.) UNUM reasons that, since Congress knew that 80% of employee benefit plans are insured, if it really had intended to exempt state insurance regulations such as the notice-prejudice rule from preemption, and had thereby intended to allow these legions of insured plans to be subjected to non-uniform state regulation, Congress would have belabored this fact in ERISA's 15-volume legislative history. (Pet. Br. 18-19.) UNUM claims that "Congress simply could not have intended such a dramatic exception to its regulatory scheme without some affirmative indication to that effect." (Pet. Br. 19.)

Of course, the "affirmative indication" that UNUM seeks is to be found, as this Court has repeatedly held, in the *text* of the saving and deemer clauses. UNUM's proposal that the Court rewrite ERISA's text not on the basis of what Congress said about these clauses in the legislative history, but on the basis of "Congress' *silence* on this subject," (Pet. Br. 19, emphasis added), is a perilous approach to statutory construction that would subvert the proper constitutional relationship between the legislature and the judiciary. This Court should not entertain

UNUM's "speculative attempt to read the saving clause out of the statute." *Metropolitan Life*, 471 U.S. at 747.[29]

II. ERISA DOES NOT PREEMPT CALIFORNIA'S GENERAL LAWS OF AGENCY BECAUSE THOSE LAWS DO NOT "RELATE TO" ERISA PLANS WHEN APPLIED TO THE RELATIONSHIP BETWEEN AN INSURER AND ITS AGENTS.

A. The Ninth Circuit Decided This Case Based On The Application Of General Agency Law, *Not* The *Elfstrom* Rule.

Although the *Elfstrom* decision, which pre-dated ERISA's enactment, does not expressly refer to "ERISA plans,"

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[29] UNUM's final point is both confused and confusing. (Pet. Br. 37-38.) Petitioner appears to argue that because ERISA "specifically relates" to insurance, the clause in § 2(b) of the McCarran-Ferguson Act that prevents state laws that regulate insurance from being "impaired, invalidated or superceded" by federal legislation (such as ERISA) unless that legislation "specifically relates" to insurance, 15 U.S.C. §1012(b), has no application in this case. UNUM thus appears to be arguing that, under the McCarran-Ferguson Act, ERISA "specifically relates" to insurance and therefore governs this case. Ward is unsure what this is supposed to add to the debate, since he agrees that ERISA controls here and that its Section 514(a) would preempt the notice-prejudice rule in the absence of the saving clause. Of course, the saving clause in Section 514(b)(2)(A) does preserve the rule as a state regulation of insurance. The only other possible interpretation of this puzzling argument is that UNUM is saying that, even if ERISA itself saves the notice-prejudice rule, some contorted combination of ERISA and the McCarran-Ferguson Act somehow preempts the rule nevertheless — and that makes no sense at all.

the group insurance plans the rule targets would appear to be ERISA welfare plans under 29 U.S.C. § 1002(1). *See District of Columbia v. Greater Washington Board of Trade*, 506 U.S. 125, 130 (1992). Respondent therefore assumes arguendo that the California Supreme Court's *Elfstrom* rule "relates to" ERISA plans because it makes reference to ERISA plans and is premised on the existence of a plan. *See Ingersoll- Rand Co. v. McClendon*, 498 U.S. 133, 140 (1990).

But this does not end the preemption inquiry because the court below did not actually apply the *Elfstrom* rule in this case. Instead, the court of appeals reformulated the rule, from one holding that employers who administer insured plans are agents of the insurer *as a matter of law*, to one based on a *factual inquiry* about the employer's status under general principles of agency law. The clearest indication of this decisive departure from *Elfstrom* is the court's disposition of this case — the court remanded for a factual inquiry into whether MAC was UNUM's agent, whereas under *Elfstrom* that question would have been resolved as a matter of law and there would have been no need for a remand.

The court also demonstrated that it was not applying *Elfstrom* literally when it endorsed the "formulation" of the *Elfstrom* rule suggested in *Paulson v. Western Life Ins. Co.*, 636 P.2d 935 (Or. 1981) (Pet. App. 12a, 13a n.6). In *Paulson*, the Oregon Supreme Court reconciled the split between cases like *Elfstrom*, which held that an employer which administered a group insurance plan was the insurer's agent as a matter of law, with cases from other jurisdictions reaching a contrary conclusion. The Oregon court explained that the differing outcomes were the result of variations in the role the employer

actually undertook, and that in most cases the employer's status as an agent presented a question of fact. (Pet. App. 13a, n.6.)[30]

The fact that the court below did not actually apply the *Elfstrom* doctrine largely disposes of petitioner's argument for preemption under ERISA, because UNUM predicates its argument almost exclusively on whether the specific *Elfstrom* rule as such, rather than the common law of agency in general, makes reference to and is premised upon the existence of, and hence "relates to," ERISA plans. (*See* Pet. Br. 41.)[31]

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[30] The court of appeals' application of general agency principles was also evident in the court's rejection of UNUM's claim that the literal terms of its policy trumped California agency law. The court stated, "Ostensibly, the legislative effort was to ensure that employee benefits are provided through an ERISA plan overseen by plan fiduciaries, including the plan insurer and those who the insurer may enlist to participate in the administration of the plan. Nothing in § 514(a) empowers a plan fiduciary to extend ERISA's preemptive reach by using policy language that negates agency law principles in favor of exonerating itself from the errors of those who act on its behalf." (Pet. App. 22a.)

[31] UNUM cites *Jass v. Prudential Health Care Plan*, 88 F.3d 1482, 1488-89 (7th Cir. 1996), for the proposition that "ERISA preempts agency rules" because they have "'the effect of regulating the structure or administration of ERISA plans.'" (Pet. Br. 41) (purporting to quote from the *Jass* opinion). But no such language or point appears on the cited pages. Instead, *Jass* holds that a state law tort claim against a plan officer for refusing to authorize payment for medical treatment is preempted by ERISA's exclusive remedy provisions. 88 F.3d at 1488-89. That holding, while correct, has no bearing on this case because, as explained above, Ward has not sought to circumvent ERISA by bringing a state-law cause of action. Rather, unlike the plaintiff in *Jass*, he has sought only plan benefits under ERISA.

B. General Agency Law Principles Do Not Refer To Or Have A Connection With ERISA Plans.

Section 514(a) of ERISA states that the statute preempts state law insofar as it "relates to" ERISA plans. In this Court's "earlier preemption cases, it had not been necessary to rely on the expansive character of ERISA's literal language in order to find preemption," because the state laws at issue there "had a clear 'connection with or reference to' ERISA benefit plans." *De Buono v. NYSA-ILA Medical And Clinical Services Fund*, 520 U.S. 806, 117 S.Ct. 1747, 1751 (1997).

Clearly, California's rules of agency, including the rule that permits notice to an agent to be imputed to the principal in some circumstances, do not refer to ERISA plans — nor does UNUM contend otherwise. Those rules apply generally to any person or entity that chooses to arrange its relationships in a fashion that brings the agency rules into play. The rules do not single out employee benefit plans, nor do they require the existence of a plan to operate. California's agency rules therefore do not "make 'reference to' ERISA plans in any manner." *Travelers*, 514 U.S. at 656 (observing that New York's surcharges on patients and HMOs do not "refer to" ERISA plans).

It is a far more difficult question whether application of agency principles, in the manner they might be applied here on remand, could nevertheless be said to "relate to" a plan sufficiently to result in preemption. And, of course, it is not a question that the Court needs to reach to resolve this case, because the judgment below can be affirmed solely upon an application of the notice-prejudice rule. *See* Part I above.

The difficulty in deciding whether general agency rules "relate to" ERISA plans lies in the fact that this Court's most recent decisions have flatly rejected "an expansive and literal interpretation of the words 'relate to' in §514(a) of ERISA." *De Buono*,117 S.Ct. at 1751. That "text could not be read to 'extend to the furthest stretch of its indeterminacy, [or] for all practical purposes preemption would never run its course.'" *Id.* (quoting *Travelers*, 514 U.S. at 655). Accordingly, the Court has "unequivocally concluded" that ERISA did not "modify 'the starting presumption that Congress does not intend to supplant state law.'" *De Buono*, 117 S.Ct. at 1752 (quoting *Travelers*, 514 U.S. at 654).

In *Travelers*, *De Buono* and *Cal. Div. Of Labor Enforcement v. Dillingham Construction Co.*, 117 S.Ct. 832 (1997), the Court held that state laws that indirectly affected the choices available to ERISA plans in the marketplace did not "relate to" ERISA plans. In *Dillingham*, the Court held that a California prevailing wage law does not "relate to" ERISA plans because it merely "alters the incentives, but does not dictate the choices, facing ERISA plans." 117 S.Ct. at 842. The law did not require ERISA plans to do anything — it merely created incentives to use apprentices participating in state-approved programs because those apprentices could be paid a lower wage than apprentices from non-approved programs. *Id.* at 841. The Court concluded that it "could not hold preempted a state law in an area of traditional state regulation based on so tenuous a relation without doing grave violence to our presumption that Congress intended nothing of the sort." *Dillingham*, 117 S.Ct. at 842.

Similarly, *Travelers* held that a state law imposing higher surcharges on hospital rates for patients insured by commercial insurers than those insured by Blue Cross/Blue Shield did not "relate to" ERISA plans, even though it raised the cost of

commercial insurance policies purchased by ERISA plans. 514 U.S. at 662. The Court found that this sort of indirect influence on plans — which might provide an incentive for a plan to favor one arrangement over another, but which did not "force" plans "to adopt a certain scheme of substantive coverage" or "restrict [their] choice of insurers" — did not have a sufficient connection with ERISA plans to trigger preemption. 514 U.S. at 668.

Most recently, in *De Buono*, the Court held that a state tax on the gross receipts of hospitals, including hospitals owned and operated by ERISA plans, did not "relate to" ERISA plans. 117 S.Ct. at 1752. The plans were left with the choice of how to arrange to provide health care benefits for their members, with one option being ownership of a hospital subject to the state's tax. Therefore, that state tax law was merely "one of 'myriad state laws' of general applicability that impose some burdens on the administration of ERISA plans but nevertheless do not 'relate to' them within the meaning of the governing statute." 117 S.Ct. at 1752.

Here, as in *De Buono*, *Travelers* and *Dillingham*, California's agency rules do not bind ERISA plans to any particular choice. Agency rules simply function in a way that makes certain choices have certain consequences. That is, *if* an insurer *chooses* to involve an employer or other entity in administering its insurance policy, that entity may under some fact patterns be deemed an agent, and notice to the agent may then be imputed to the principal.[32] The choice to involve MAC

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[32] California Civil Code § 2332 governs the imputation of notice. It provides, "As against a principal, both principal and agent are deemed to have notice of whatever either has notice of, and ought, in good faith and the exercise of ordinary care and diligence, to communicate to the other."

in administering its policy was entirely UNUM's. Granted, California's agency rules may have some effect on UNUM's choices in plan administration, but many state laws of general application "will have some effect on the administration of ERISA plans, [and] that simply cannot mean that every state law with such an effect is preempted by the federal statute." *De Buono*, 117 S.Ct. at 1753. ERISA does not preempt state laws that have only a "'tenuous, remote or peripheral' connection with covered plans . . . as is the case with many laws of general applicability." *Greater Washington Board of Trade*, 506 U.S., at 130 n. 1. As in *De Buono*, Travelers, and *Dillingham*, in this case any effect on the plan from application of state agency law principles is indirect and incidental.

Contrary to UNUM's apparent position, ERISA does not generally forbid the application of state law principles. "ERISA leaves room for complimentary or dual federal and state regulation, and calls for federal supremacy when the two regimes cannot be harmonized or accommodated." *John Hancock Mut. Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86, 98 (1993). Here, there is no direct conflict between ERISA and the background principles of agency law because ERISA is silent on the issue of agency.[33]

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[33] Although the United States argues that the *Elfstrom* rule itself is preempted (U.S. Br. 26), it does not argue that general agency principles are at odds with anything in ERISA. Indeed, in suggesting that the *Elfstrom* rule might properly be adopted as a matter of federal common law under ERISA (*id.* at 28), the United States makes clear that the rule in no way conflicts with any aspect of the statute. If the Court were to hold that ERISA preempts the application of California agency principles here, Ward would concur in the suggestion of the Solicitor General that, on remand, the courts below should consider whether the agency principles relied upon by the Ninth Circuit should apply to the circumstances of this case as a matter of federal common law.

This case does, of course, differ from *De Buono*, *Travelers*, and *Dillingham* in one respect — the state laws at issue in those cases did not have any impact on whether a particular claimant would receive plan benefits. Here, California law might permit MAC's knowledge to be imputed to UNUM, which could, indirectly, trigger UNUM's obligation to pay Ward's claim. But the fact that state-law agency rules might intersect the administrative process for delivering ERISA benefits is not determinative. In *Mackey v. Lanier Collection Agency & Service, Inc.*, 486 U.S. 825 (1988), the Court held that state-law mechanisms to collect a judgment could be applied against a plan "even when those mechanisms prevent plan participants from receiving benefits." *Id.* at 831-832.

In *Mackey* the United States argued, as it does here, U.S. Br. 27, that the state law must be preempted because its application to ERISA plans would cause them to "incur substantial administrative burdens and costs." 486 U.S. at 831. And the Court in *Mackey* was likewise urged to find preemption lest interstate ERISA plans be subjected to "varying or conflicting state laws." *Id.* at 842 (dissenting opinion). But both arguments were rejected by this Court.

Mackey recognized that ERISA plans were frequently sued for "run-of-the-mill state-law claims" such as unpaid rent, failure to pay creditors, or even torts committed by the plan. 486 U.S. at 833. Yet the Court observed that "these suits, although obviously affecting and involving ERISA plans and their trustees, are not preempted by ERISA § 514(a)." *Id.* The Solicitor General suggested that the textual phrase "relates to" might be subject to situational elasticity: State-law mechanisms to collect judgments would not generally be deemed to "relate

to" ERISA plans (and hence would not be preempted), *except* when those mechanisms "affect whether benefits will be paid to a plan participant." 486 U.S. at 835. The Court found that the text could not support such a distinction:

> [T]here is simply no logical way to construe the English language so that garnishment or attachment laws "relate to" benefit plans when they are invoked by creditors of the beneficiaries, but not when they are by beneficiaries or creditors of the plan itself.

486 U.S. at 836.

The same analysis should govern here. There is no doubt that state agency law principles would apply in the "run-of-the-mill state-law" lawsuits discussed in *Mackey*: For example, in an action for unpaid rent brought by a landlord on the basis of a lease signed by a party alleged to be the agent of a plan insurer. If California's agency principles do not "relate to" the plan when they are invoked in litigation by a putative creditor of the plan, it is hard to see why they would "relate to" the plan in litigation brought by a plan participant.

CONCLUSION

For the reasons given above, the judgment below should be affirmed.

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REPLY BRIEF FOR PETITIONER

I. THE NOTICE-PREJUDICE RULE IS NOT A STATE LAW THAT REGULATES INSURANCE.

A. The Notice-Prejudice Rule Is, In Substance, The Particular Application To An Insurance Contract Of A Widely Recognized General Common Law Principle.

Respondent and the Solicitor General make much of the fact that the notice-prejudice rule has not been applied "by its terms," or "as such," in California cases that do not involve insurance policies. (Brief for Respondent ("Ward Br.") at 16; Brief for United States ("U.S. Br.") at 12). From this observation, they conclude that the notice-prejudice rule is "specifically directed at the insurance industry," and thus, from a common-sense viewpoint, regulates insurance. This line of reasoning rests upon an

unrealistic and superficial understanding of the common law.

A widely but not universally recognized principle of common law allows failures to satisfy contractual forfeiture provisions, such as conditions precedent, to be ignored as immaterial in appropriate circumstances. "To the extent that the non-occurrence of a condition would cause disproportionate forfeiture, a court may excuse the non-occurrence of that condition unless its occurrence was a material part of the agreed exchange." *Restatement (Second) of Contracts*, § 229. Two months ago, the Tennessee Supreme Court expressly relied upon Restatement section 229 to support the adoption in Tennessee of the "notice-prejudice rule" in the context of deciding on a claim for insurance benefits. *Alcazar v. Haye*, 1998 Ten. LEXIS 749 (Dec. 1998) (For Publication). So, too, Connecticut ten years ago cited to section 229 in adopting the notice-prejudice rule. *Aetna Cas. and Sur. Co. v. Murphy*, 206 Conn. 409 (1988).

California courts apply the principle that a non-material breach might not cause a forfeiture in many situations. *E.g., Ruben v. Fuchs*, 1 Cal.3d 50, 54 (1969) (real estate contract not voided by buyer's failure to post funds by a certain date); *Sosin v. Richardson*, 210 Cal.App.2d 258, 264 (1962) (contract provision not construed as "condition precedent" unless plainly stated). *See Hopkins v. Woodward*, 216 Cal. 619 (1932) (equitable relief against forfeiture of contract to produce a play); *Henck v. Lake Hemet Water Co.*, 9 Cal.2d 136, 143 (1937) (water contract case; Cal. Civ. Code § 3275 provides relief from forfeiture of contract rights); *O'Morrow v. Borad*, 27 Cal.2d 794, 800-801 (1946) (insurance case observing that equitable relief against forfeiture applies broadly in both insurance and other contract cases); 1 Witkin, *Summary of Cal. Law* (9th ed. 1987), Contracts § 771 (discussing equitable relief agaist forfeitures and citing *Restatement (Second) of Contracts*, § 229).

Against this background, the issue fairly posed is whether application of section 229 concepts to a contract that is an insurance contract is a regulation "specifically directed to the insurance industry" or is, instead, an application of a common law principle whose roots "are firmly planted in the general principles of . . . contract law." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987).[1] Respondent and his supporting *amici* would have the answer to this question turn on mere labels. If the state court, like Tennessee's or Connecticut's, announces in an insurance contract case that it is applying Restatement section 229, then the application does not constitute a law regulating insurance. On the other hand, if a state, like California, applies the principle but gives it in each context its own name without reference to section 229, then the same law suddenly becomes a law that regulates insurance. Such an argument substitutes rubric for reason.

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[1] The Solicitor General suggests that UNUM "belatedly" raised in its reply brief at the *certiorari* stage the issue whether the notice-prejudice rule was "nothing more than a basic rule of contract law." (U.S. Br. at 11). The argument that the notice-prejudice rule is "not specifically directed at the insurance industry," *Pilot Life*, 481 U.S. at 50, is an argument that is directly in support of Petitioner's position on the first and second questions presented, and is in any event akin to the third McCarran-Ferguson criterion. *See* U.S. Br. at 13 ("as discussed above"). In its petition in this case, UNUM discussed the notice-prejudice issue at pages 5-7, 9-11, and 14-18.

Ward also notes that UNUM did not raise the issue of the notice-prejudice rule at all in its brief as appellee before the Ninth Circuit in this case. (Ward Br. at 14). This is true. Ward's complaint was barren of any suggestion of his intent to rely on the notice-prejudice rule (Pet. at 77a-80a). As evidenced by the District Court's order he did not raise the issue at all below (Pet. at 27a-33a). UNUM below naturally did not address the rule in this case, as opposed to *Cisneros v. UNUM Life Ins. Co. of America*, 134 F.3d 939 (9th Cir. 1998), until after it was raised *sua sponte* by the Ninth Circuit.

If the "label is everything" argument were accepted, even the *Elfstrom* rule would be a law regulating insurance because it is similarly impossible to find a single instance in which the *"Elfstrom"* rule is applied "as such" outside the insurance industry. Yet both Ward and the Solicitor General admit that the Ninth Circuit's agency law ruling in this case is nothing but the application of general agency principles applied in the context of group insurance. (Ward Br. at 35-36; U.S. Br. at 27-28, n.16). Applying general agency principles to insurance and calling them "the *Elfstrom* rule" no more creates regulation "specifically directed at the insurance industry" than calling Restatement section 229 principles "the notice-prejudice rule."

Respondent and his supporting *amici* would also have the inquiry turn on the chronological happenstance of each state's development and application of common law principles. If California, for example, had first adopted the notice-prejudice rule "as such" in a landlord/tenant case, then it would presumably follow that its subsequent adoption in an insurance case would not be a law regulating insurance. And what if California, tomorrow, were to apply the notice-prejudice rule in one or several other, non-insurance contexts? Would the law that is today said to be a law regulating insurance suddenly, *nunc pro tunc*, cease to be a law regulating insurance?

The point—which Respondent and his supporting *amici* ignore—is that, from a common-sense viewpoint, the common law in both its development and its application is not readily amenable to being regarded as a regulatory law. Courts generally do not think of themselves as "regulating" an industry (with the possible exception of the legal industry). Rules may evolve in cases arising in the context of particular industries because courts are limited to adjudicating specific controversies that come before them on a case-by-case basis. Thus, for example, even though the rule of strict liability for ultrahazardous activity was first developed (by another name) in a case involving the storage of waters upon land, *Rylands v. Fletcher*, House of Lords, 1868 L.R.3d H.L. 330, one would hardly describe the rule as a "land or water regulatory law." Rather, it was the adoption in a particular context of a principle that under various different names has been since applied in other contexts.[2]

B. To A Significant And Dispositive Extent, Respondent Fails To Demonstrate That The McCarran-Ferguson Criteria Are Satisfied.

Where, as here, the state law in question falls short of satisfying a common-sense definition of a law that regulates insurance, the Court should either end the inquiry, or at least require an especially strong satisfaction of the three McCarran-Ferguson criteria in order to find the law to be a law that regulates insurance. To the contrary, Respondent and his supporting *amicus* are forced to ask the Court to adopt what is fairly described as strained or diluted constructions of those criteria. In this respect, this case aptly demonstrates why all three McCarran-Ferguson criteria should be met before declaring that a law regulates insurance. The three criteria are interrelated to such an extent that a failure to satisfy any one serves as a warning that none is likely to be satisfied in a meaningful sense that is relevant to the inquiry at hand.

Regarding risk spreading, Respondent and the Solicitor General concede that the Ninth Circuit's conclusion—that the rule accomplishes no relevant risk transfer—is "not without support in the decisions of the lower federal courts." (Ward Br. at 24). Nevertheless, Respondent urges that the notice-prejudice rule effects risk spreading

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[2] The Solicitor General's observation that a common law rule fits ERISA's definition of a "state law," 29 U.S.C. § 1144(c)(1) (U.S. Br. at 12, n.5) does not mean that common law rules, as compared to statutes and regulations, are as easily determined to be state laws "which regulate[] insurance." 29 U.S.C. § 1144 (b)(2)(A).

"to ensure the policy will be performed to the insured's benefit in circumstances where, in the absence of the rule . . . there would be no performance, and hence no risk-spreading." *Id.* at 25. In other words, it can be outcome determinative. Yet, virtually any rule or procedure employed in adjudicating a dispute over a claim for benefits under an insurance policy can be outcome determinative. Evidentiary rules, a right to jury trial, the unconscionability doctrine, and so on, all satisfy this diluted notion of risk spreading.

Risk spreading, instead, is the process whereby the insurer contracts to reimburse the insured for a particular hazard or loss of which he or she is at risk. "As we appreciate the term 'spreading of risk' in the context of an insurance policy, the risk focused upon is that risk for which the insurance company has specifically contracted to reimburse the insured." *Tingle v. Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 n.13 (5th Cir. 1993) (state statute shifting burden of innocent misrepresentations in policy applications to the insurer does not act to spread risk).[3] The requirement of a timely, post-loss claim is not an insurable risk to be transferred in this important sense. Rather, like satisfying a statute of limitations, or submitting a signed claim form, it is simply a condition to administering and enforcing whatever transfer has been agreed upon. Therefore, unless that which this Court has correctly deemed to be "an indispensable characteristic of insurance," *Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 211 (1979), is now to be

[3] *United States Dept. of Treasury v. Fabe*, 508 U.S. 491, 503-504 (1993), is not to the contrary. The majority opinion (described by the dissent as a "compromise," 508 U.S. at 517) simply held that a state insurance statute prioritizing payment of the agreed-upon reimbursement satisfies McCarran-Ferguson. A broad reading of the opinion to suggest that any state common law affecting whether an individual's claim is paid equates to risk spreading is unwarranted by the facts of the case, and would eliminate any distinction between risk spreading and dispute resolution.

deemed dispensable, the Ninth Circuit's holding should be reversed.

Regarding the second factor [Is the practice integral to the insurance policy relationship between the insurer and the insured?], administering claims and determining whether conditions for payment are met are processes that are regularly performed by non-insurers. While such activity relates to and arises out of the policy relationship, it can hardly be said to be integral to that relationship (unless everything that relates to it is "integral"). As the California Court of Appeal itself has recognized, the "bold assertion" that " '[c]laims adjustment is part of the insurance industry and is limited to it by definition' " is "inaccurate since case law demonstrates that many third party administrators of employee benefit plans are not insurance companies." *Bruenn v. Aetna Life Ins. Co.*, 197 Cal.App.3d 1000, 1005 (1987). Claims administration activity often is the province of employers, trustee committees or peer review organizations. *See Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982); *Powell v. Chesapeake & Potomac Telephone Co.*, 780 F.2d 419, 423-424 (4th Cir. 1985), *cert. denied*, 476 U.S. 1170 (1986).

Finally, the defects in Respondent's arguments concerning the third criterion [Is the practice limited to entities within the insurance industry?] are fairly summarized in the foregoing paragraph of this Reply, and in part I.A, *supra*. Unless all of the McCarran-Ferguson factors are stretched beyond the point at which they lose meaningful application, the notice-prejudice rule fails to satisfy, certainly collectively, the relevant criteria for being classified as a law that regulates insurance.

II. EVEN IF CALIFORNIA'S NOTICE-PREJUDICE RULE WERE A LAW THAT REGULATES INSURANCE, IT COULD NOT MANDATE THE RULE OF DECISION IN A SECTION 502(a) ACTION FOR BENEFITS DUE UNDER THE TERMS OF THE PLAN.

A. Notwithstanding The Saving Clause, ERISA Preempts All Conflicting State Insurance Regulation.

The Solicitor General, whose predecessor successfully urged the Court in *Pilot Life* to sustain the fully federal character of ERISA civil enforcement actions, now shrinks from the logic and force of this Court's unanimous pronouncement. He relegates to a footnote his recognition of the fact that, notwithstanding the saving clause, state laws that regulate insurance (and are thus within the literal language of the savings clause read out of context) are nevertheless preempted if they stand as "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." (U.S. Br. at 24, n.13). In the substance and logic of his argument, the Solicitor General then renders his footnoted recognition of conflict preemption meaningless. He contends that conflicts between the provisions of ERISA and state laws regulating insurance are to be resolved by construing ERISA section 502 (and presumably all provisions of ERISA) so as to eliminate the conflict. In the words of the Solicitor General: "Accordingly, the saving clause by its terms directs that nothing in section 502, which concerns causes of action and remedies under ERISA, shall be 'construed' to relieve or exempt any person from 'any law' of a state that regulates insurance." *Id.* at 23.

This approach to applying the saving clause turns the proper analysis on its head. An understanding of ERISA's comprehensive, federal civil enforcement provisions is not informed by the saving clause. Exactly the opposite is true. As this Court has stated, "our understanding of the saving clause must be informed by the legislative intent

concerning the civil enforcement provisions provided by ERISA, section 502(a)." *Pilot Life*, 481 U.S. at 51-52. *See also John Hancock Mut. Life Ins. Co. v. Harris Trust and Sav. Bank*, 510 U.S. 86 (1993). In *John Hancock*, this Court held that ERISA itself regulates insurance, that the saving clause was only intended to save "complementary or dual regulation of insurance" by states, and that "in the case of a direct conflict, federal supremacy principles require that state law yield." 510 U.S. at 100 (*quoting* U.S. Br. at 23, n.13). In short, it is the saving clause itself that is to be construed so that it is in harmony with the provisions of ERISA, rather than those provisions being constrained to be in harmony with the saving clause. State insurance law that satisfies the literal language of the saving clause, yet conflicts with a provision of ERISA, is therefore preempted.

B. California's Notice-Prejudice Rule Intrudes In An Area Of Field Preemption And Also Directly Conflicts With At Least Two Central Aspects Of ERISA.

1. *Mandating the application of a state law rule of decision in a suit involving benefit rights brought under section 502(a) clashes with the preemptive force of that section as shown by Congress's intent that federal law control the administration and enforcement of benefit rights and obligations under ERISA plans.*

Respondent purports to bring a claim "to recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132(a)(1)(B). Respondent and his supporting *amici* argue that, in determining what benefits are due to him under the terms of his plan, a federal court must apply what the Solicitor General calls a "rule of decision" developed by California courts under California common law. (U.S. Br. at 18 & 19). To accept this notion—that California law should mandate the "rule of decision" in a federal cause of action involving benefit claims

brought under the civil enforcement scheme of ERISA—is to thwart ERISA's purpose of governing such suits exclusively under federal law in a manner similar to that employed in section 301 of LMRA. It is also to reject the unanimous holding of this Court in *Pilot Life* that Congress intended "that all suits brought by beneficiaries or participants asserting improper processing of claims under ERISA-regulated plans be treated as federal questions . . . ." 481 U.S. at 56.

> The uniformity of decision which the act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to state laws.

Id. (*quoting* H.R. Rep. No. 95-533, p. 12 (1973), *reprinted in 2 Senate Committee on Labor and Public Welfare, Legislative History of ERISA*, 94 Cong., 2d session, 2359 (Comm. Print 1976)).

Betraying his acquired dislike for Congress's chosen federal scheme of claims administration and enforcement, the Solicitor General states that ERISA "contains some provisions regarding claims processing." (U.S. Br. at 9). This begrudgingly cramped description of the statute hardly captures the significance and comprehensiveness of what Congress has done. As this Court has noted, the detailed provisions of section 502(a) "set forth a comprehensive civil enforcement scheme that represents a careful balancing of the need for prompt and fair claims settlement procedures against the public interest in encouraging the formation of employee benefit plans." *Pilot Life*, 481 U.S. at 54. Congress intended that section 502(a) suits to enforce benefit rights or to recover benefits "will be regarded as arising under the laws of the United States, in similar fashion to those brought under section 302 of the Labor-Management Relations Act." 120 Cong. Rec. 29933 (1974) (remarks of Sen. Williams).

Congress did not intend that federal courts adopt a patchwork of state law rules of decision to be brought to bear in construing and enforcing (or, as here, not enforcing) rights of beneficiaries and obligations of fiduciaries under ERISA benefit plans. Precisely to the contrary, Congress "intended that a body of *Federal* substantive law will be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans." *Pilot Life*, 481 U.S. at 56 (*quoting* remarks of Sen. Javits) (emphasis supplied). This is an area of field preemption. State law is "*not* . . . an independent source of private rights in this area." *Textile Workers Union v. Lincoln Mills*, 353 U.S. 448, 457 (1957) (section 301 case). Mandating application of the California rule of decision in this section 502(a) action for benefits due under the terms of the plan directly conflicts with that intent, and should therefore be rejected.

2. *The California rule of decision directly conflicts with ERISA's mandate that benefits be paid in accord with the written plan instrument.*

In section 402(a)(1) of ERISA, Congress stated: "Every employee benefit plan shall be established and maintained pursuant to a written plan instrument." 29 U.S.C. § 1102(a)(1). Congress's mandate that employee benefit plans be established and maintained pursuant to a written plan instrument is one of ERISA's "core functional requirements." *Curtis-Wright Corp. v. Schoonejongen*, 514 U.S. 73, 84 (1995). Congress's written plan instrument mandate ensures that plan beneficiaries and participants can verify and determine for themselves precisely what their rights, duties and obligations are under these plans that are important to their welfare and security. Congress mandated that the plan administrator "shall make copies of the . . . instruments under which the plan was established or is operated available for examination by any plan participant or beneficiary in the principal office of the administrator and in such other places as may be necessary to make available all pertinent information to all participants . . . ." 29 U.S.C. § 1024(b)(2). Congress mandated that summaries of

the plan be furnished to beneficiaries, 29 U.S.C. § 1024 (b)(1) & (2), and such summaries must describe the conditions of forfeiture. 29 C.F.R. 2520.102-3.[4] Congress also required that the plan administrator supply, upon written request by any participant or benficiary, a copy of, among other things, the "instruments under which the plan is established or operated." Any plan administrator that fails to comply with the request from a plan participant for a copy of the written plan instrument is subject to a civil enforcement penalty under 29 U.S.C. § 1132(c).

Having settled on the device of a mandatory and complete writing, Congress further specified the role that the written plan instrument must play. Most importantly for purposes of this case, Congress plainly and unambiguously requires that any plan fiduciary, like UNUM, "shall discharge his duties . . . in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of this subchapter and subchapter III." 29 U.S.C. § 1104 (a)(1)(D).[5]

Respondent and his supporting *amici*, however, would require UNUM, as the plan fiduciary, to pay benefits to

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[4] It is undisputed that such a summary, describing the notice of claim provision, was given to Ward. Pet. App. at 2a & 41a-43a.

[5] The federal courts have consistently barred participants' efforts to use state common-law waiver and estoppel doctrines to obtain benefits that are not "due" under the plan's written terms. *See Cinelli v. Security Pacific Corp.*, 61 F.3d 1437, 1444 (9th Cir. 1995) ("Consistent with the ERISA's strong preference for the written plan, we do not allow an estoppel claim to lie where it would contradict the written terms of the plan"); *Thomason v. Aetna Life Insurance Co.*, 9 F.3d 645, 648-649 (7th Cir. 1993) (claim for waiver not permitted to proceed where it contradicts the plan language). Conversely, at least some lower courts have seemingly "read into" plans state-mandated benefit coverage without attempting to reconcile such with the written plan instrument rule. *See Donatelli v. Home Ins. Co.*, 992 F.2d 763, 764 (8th Cir. 1993) (mandated "insanity" suicide coverage).

Mr. Ward even if they are not due to him under the written plan instrument if his failure to qualify under the terms of the written plan instrument causes no prejudice to UNUM. The California rule of decision—pay benefits even if not called for under the written plan instrument if there is no prejudice—thus directly conflicts with UNUM's principal obligation under federal law—to discharge its duties in accordance with the written plan instrument.

The Solicitor General sidesteps the direct conflict between ERISA's statutory rule of decision that fiduciaries follow the written terms of the plan and the California rule of decision that the fiduciary here might be required to pay benefits not in accordance with the terms of the written plan document. He simply suggests that the written plan document requirements of ERISA "could not reasonably be read to require fiduciaries to follow a plan's terms in contravention of applicable federal or state law." (U.S. Br. at 19, n.9). Of course there is no issue in this case of any conflict between the plan's terms and any applicable federal law. It is undisputed that both the plan and UNUM's conduct have been in keeping in all respects with the requirements of all applicable federal law. Federal regulations allow plans to set deadlines for filing claims so long as the time period is "reasonable" and satisfies a detailed list of notice and content requirements. 29 C.F.R. § 2560.503.1(b)-(d). No one asserts that the deadlines here do not comply with those federal requirements. The question is whether the fiduciary and the Court must follow a federal rule of decision or a state rule of decision. Nor is there any question of UNUM's not complying with a state law when it wrote and issued its policy. There is no suggestion that any insurance regulator has disapproved the terms of the policy. *See* Cal. Ins. Code §§ 10290, *et seq.* (prohibiting the sale of policies without commissioner approval). Nor is this a case, such as *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985), in which an insurer seeks to omit from a policy a mandated benefit regarding which Congress has not opted for a uniformly federal scheme. Were it such

a case, the California insurance regulators—as did the Massachusetts regulators in *Metropolitan*—could presumably bring a state action to enjoin use of the non-complying form.

Respondent and his supporting *amici* alternatively advance a fiction: The California notice-prejudice rule of decision should be "incorporated into" the terms of the plan, or has "changed" those terms. (U.S. Br. at 18; Ward Br. at 31). Adoption of such a fiction for a rule of decision like notice-prejudice is, at base, rejection of the written plan instrument rule in a context in which ERISA itself directly regulates the applicable standards. Neither beneficiaries nor fiduciaries will be able to determine the procedures for making claims without researching state decisional law. Such laws might not always be "pro-insured." For example, some states, including California, preclude beneficiaries from recovering benefits due if the illness or injury is intentionally self-inflicted. Cal. Ins. Code § 533 ("An insurer is not liable for a loss caused by the willful act of the insured.").

The conflict between California's notice-prejudice rule and ERISA's "follow the written plan instrument" rule is especially pronounced because ERISA plans are usually plans that insure many employees. Premiums under group plans sold to employers may be experience-rated, and are often paid for (as here) by employer withholding from employee compensation. Some insurance plans, such as group annuity contracts funding retirement plans, may have benefit levels that are not fully guaranteed. *See, e.g., John Hancock, supra.* For these reasons, uncalled for payments to a plan beneficiary under an ERISA plan may affect *other* beneficiaries. All beneficiaries and participants who are so harmed are therefore entitled to bring actions to "enforce . . . the terms of the plan." 29 U.S.C. § 1132 (a)(3)(B)(ii). The California rule of decision, by contrast, generally presumes a two-party relationship. It thus gauges only "prejudice to the insurer," and by definition presumes that a payment not called for by the written plan causes no material harm. In short, it does not fit

into the regime of employee welfare benefit plans prescribed by Congress.

III. *PILOT LIFE* SHOULD NOT BE "NARROWED" OR OVERRULED.

The AARP asks the Court to overrule *Pilot Life*, and the Solicitor General suggests that *Pilot Life* might be revisited and narrowed. This Court may easily dispose of the AARP's argument. The AARP's justification for overturning this longstanding, unanimous decision, is that it supposedly interferes with recent state consumer protection statutes. The AARP nevertheless appears unable to present a single example of this alleged interference. (AARP Br. at 9). None of the state laws cited by AARP is impacted by *Pilot Life*'s holding that ERISA provides the exclusive civil enforcement mechanism for benefit claims.

The Solicitor General suggests that Congress did not intend that section 301 of the LMRA should serve as the model for ERISA suits in which the claim for plan benefits is based on "a state-law cause of action or remedy that 'regulates insurance'." (U.S. Br. at 25). The suggestion is without support in the legislative history or the text of ERISA or McCarran-Ferguson. Additionally, the Solicitor General does not demonstrate that a "state-law cause of action or remedy" that would not regulate the "business of insurance" under the McCarran-Ferguson Act nonetheless is "saved" by ERISA. He also overlooks the fact that the Court *resolved* the potential tension between the preemption and saving clauses of ERISA by explaining in *Pilot Life* that Congress had an overriding intent that suits over benefit disputes should "arise under" and be governed by preemptive federal law in the same manner as suits under section 301. 481 U.S. at 52.

Other than this, the Solicitor General justifies his change of position on "significant experience with ERISA preemption in the intervening 12 years." (U.S. Br. at 25-26, n.14). He does not say *what* events occurred to cause

this extraordinary change in position from the Solicitor General's May 1986 *amicus* brief. Congress's intent that ERISA suits for plan benefits be regarded as "arising under" preemptive federal law in the same manner as suits under section 301 of the LMRA has not changed, nor has Congress amended the ERISA preemption or saving clauses or the civil enforcement provisions in a manner impacting benefit suits. Moreover, any "general" presumption that Congress did not intend federal law to displace state law must immediately disappear when the Court is confronted by a participant's suit to obtain plan benefits. As demonstrated by the House Conference Report and confirmed by *Pilot Life*, it was Congress's clear and manifest purpose to govern such suits pursuant to an exclusive civil enforcement scheme patterned on preemptive federal law under section 301 of the LMRA. The decision in *Pilot Life* and the Court's subsequent reaffirmation in *John Hancock* that ERISA preempts conflicting state insurance regulation will remain correct unless and until Congress rewrites the statute, a purely legislative task.

IV. NEITHER WARD NOR THE SOLICITOR GENERAL MAKES A COLORABLE ARGUMENT FOR APPLICATION OF STATE AGENCY LAW IN THIS CASE.

Both Ward and the Solicitor General concede, for different reasons, that the Ninth Circuit erred in holding that "ERISA does not operate to preempt the application of the state law embodied in *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503 (1967) and its progeny" (Pet. App. at 24a). Both Ward and the Solicitor General nevertheless present theories for applying the rule regardless of the Ninth Circuit's admitted error. The Solicitor General's suggestion is that the case be remanded for a determination whether "the *Elfstrom* rule, or something like it," should be incorporated into federal common law. (U.S. Br. at 28). Ward, instead, argues that the Ninth Circuit never actually applied the *Elfstrom* rule, but rather a "formulation" of *Elfstrom* that is not preempted.

A federal court creates federal common law to govern ERISA cases where ERISA itself is silent. *Butler v.*

Encyclopedia Britannica, Inc., 41 F.3d 285, 294 (7th Cir. 1994) ("courts may develop . . . a federal common law only where ERISA itself does not expressly address the issue before the court").

Conversely, the federal courts may not by application of federal common law adopt alternative resolutions of issues on which the statute is not silent. *Flacche v. Sun Life Assurance Co.*, 958 F.2d 730, 735 (6th Cir. 1992) (directive to create common law "does not imply that courts are to develop common law alternative definitions for terms that are clearly defined by statute"). ERISA itself specifies the procedures for identifying the respective roles and responsibilities of the employer, the "named fiduciary," and the plan administrator. (Pet. Br. at 42-44). (*See also* Proposed 29 C.F.R. § 2560.503-1(t)(iii)). "The plan can only act through its trustees, administrators, or others *to whom specific responsibilities have been assigned* by those trustees and administrators." 63 Fed. Reg. 48389, 48392 (Sept. 9, 1998) (emphasis supplied). Accordingly, there is simply no reason to remand, as the Solicitor General suggests, in order for the Ninth Circuit to consider whether to do what it plainly cannot do. *See also Bell v. Wolfish*, 441 U.S. 520, 532 n.13 (1979).

Ward's argument to escape the undeniable fact that the *Elfstrom* rule "relates to" ERISA plans is that the Ninth Circuit supposedly did not apply *Elfstrom*, but rather a general agency law "formulation" of *Elfstrom* based on the Oregon case of *Paulson v. Western Life Ins. Co.*, 636 P. 2nd 935 (Or. 1981). (Ward Br. at 35). Ward's support for this position is that instead of deeming the employer to be UNUM's agent, as he insists *Elfstrom* required, the Ninth Circuit remanded the case for factual development on the agency issue. This argument essentially misreads the Ninth Circuit holding that "ERISA does not operate to preempt the application of the state law embodied in *Elfstrom* and its progeny," which therefore should be "[*a*]*pplied* in the context of this case" (Pet. App. at 24a) (emphasis added). The remand was neces-

sary because *Elfstrom* did not hold that the employer was always the agent of the group insurer (*see Elfstrom*, 67 Cal. 2d at 509-510). In any event, as shown in the Brief for Petitioner at pages 42-45, and in the Brief of the United States at pages 26-28, ERISA would preempt all state agency law rules defining or governing fiduciary conduct, whatever the nomenclature given to the rules, because they directly clash with and supersede ERISA's extensive system of rules governing fiduciary and co-fiduciary duties and liabilities.

CONCLUSION

For the reasons stated in the Brief for Petitioner, as well as this Reply, the decision of the Ninth Circuit Court of Appeals should be reversed and the case remanded with instructions to affirm the summary judgment in favor of the Plan and UNUM.

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In the
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OCTOBER TERM, 1998

UNUM LIFE INSURANCE CO. OF AMERICA,
Petitioner

v.

JOHN E. WARD,
Respondent

On Writ of Certiorari to the
United States Court of Appeals for the Ninth Circuit

SUPPLEMENTAL BRIEF OF RESPONDENT

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SUPPLEMENTAL BRIEF OF RESPONDENT

Pursuant to S.Ct. Rule 25.5, respondent John Ward submits a supplemental brief addressing this Court's decision in *Humana, Inc. v. Forsyth*, No. 97-303, decided after Ward filed his brief. The *Forsyth* decision is relevant because it implicitly rejects several of the arguments on which petitioner relies in contending that the California notice-prejudice rule is not a state law that regulates insurance.

I. The Decision in *Humana, Inc. v. Forsyth*

The McCarran-Ferguson Act provides that, unless a federal statute specifically relates to the business of insurance, it cannot be applied to "invalidate, impair, or supercede any law enacted by any state for the purpose of regulating the business of insurance." 15 U.S.C. §1012(b). *Forsyth* held that the application of the RICO Act, 18 U.S.C. §1961 *et seq.*, in a lawsuit by policy beneficiaries who alleged they had been defrauded by an insurer, did not "impair" Nevada's laws proscribing fraudulent practices by insurers, and was therefore not barred by the McCarran-Ferguson Act.

The *Forsyth* decision makes clear that the Nevada laws in question included "both statutory and common-law remedies to check insurance fraud." Slip op. at 10. *See also id.* at 13 (same). The Court noted that Nevada's Unfair Insurance Practices Act, Nev. Rev. Stat. §686A.010 (1996), prohibits various forms of insurance fraud, including misrepresentation and false advertising, publication of false information, falsification of records, and fraudulent claims. Slip op. at 10-11 & n. 9. The Nevada Act provides both administrative remedies and private causes of action. Slip op. at 11. The Court also noted that Nevada permits victims of insurance fraud and bad faith to pursue common law causes of action arising out of the insurer's tortious breach of the covenant of good faith and fair dealing. Slip op. at 11.

II. Forsyth Demonstrates That A State Law May Regulate Insurance Even If It Does Not Satisfy All Three McCarran-Ferguson Act Factors.

A predicate for the application of the McCarran-Ferguson Act in *Forsyth* was the presence of a state law enacted "for the purpose of regulating the business of insurance." 15 U.S.C. §1012(b). In *Forsyth* neither party contested that Nevada's laws proscribing and punishing fraudulent practices by insurers met this definition.[1]

In this case, UNUM argues that unless a state law satisfies all three of the so-called McCarran-Ferguson factors, it cannot qualify under ERISA as a state law that regulates insurance. Pet. Br. at 23-26; Pet. Reply Br. at 5-7. These factors were developed by the Court to assist it in determining whether a particular *practice* engaged in by an insurance company constituted the "business of insurance" and was therefore made immune from antitrust regulation by the McCarran-Ferguson Act. *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).[2]

If UNUM's argument were correct, and these three factors also constituted a rigid, mandatory test for whether a state

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[1] In response to a question from Justice Kennedy during oral argument, counsel for the respondent confirmed that there was no dispute that the Nevada laws were adopted for the purpose of regulating the business of insurance.

[2] *Pireno* listed the factors as: "[F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities within the insurance industry." 458 U.S. at 129.

law *regulates* the business of insurance, then the Nevada laws at issue in *Forsyth* would necessarily have to meet all three criteria. If they did not, the McCarran-Ferguson Act would not apply.

It is clear, however, that laws preventing an insurance company from engaging in the type of misconduct at issue in *Forsyth* do not meet two of the three McCarran-Ferguson factors. As UNUM itself has conceded, laws that prohibit insurers from making false statements or engaging in unfair claims practices do not spread risk (the first factor).[3] Nor are state prohibitions on false statements or deceptive trade practices limited exclusively to entities within the insurance industry (the third factor).

Yet it is beyond dispute that Nevada's laws prohibiting insurance fraud are rules that were enacted to regulate the business of insurance. Those laws plainly regulate the relationship between the insurer and the insured by protecting insurance purchasers from deception and overreaching by insurance companies. As we previously argued, Resp. Br. at 13, 28, laws regulating this relationship, including laws against deceptive insurance practices, regulate what this Court has described as "the core" of the business of insurance.

The three McCarran-Ferguson Act factors were formulated to answer a specific question: Does a particular "practice" fall within the business of insurance? UNUM's argument substitutes the word "law" for the word "practice." As a result, the question UNUM poses is whether a particular law falls within "the business of insurance." The proper question, however, is whether the law *regulates* insurance. *Forsyth* shows that rigid application of these factors in the manner UNUM

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[3] UNUM acknowledges, Pet. Reply Br. at 6, that rules addressing the truth or falsity of statements made by the parties to insurance contracts do not involve the spreading of risk.

proposes does not consistently yield the right answer to that question even within the context of the McCarran-Ferguson Act itself, let alone within the context of ERISA, which is the statute at issue in this case.

III. *Forsyth* Shows That State Laws Derived From Common Law Doctrines Can Be Deemed To Regulate Insurance.

UNUM reads this Court's decision in *Pilot Life Ins.Co. v. Dedeaux*, 481 U.S. 41, 50 (1987), as holding that, in order to regulate insurance, a state law must not only (a) be directed at the insurance industry, but (b) must not resemble other state laws regulating other types of contracts or commerce and, indeed, (c) may not even be based on common law principles that have been found applicable outside the insurance realm. Pet. Br. 27-30; Pet. Reply Br. at 1-5.

Forsyth exposes the flaw in UNUM's position. The Nevada laws at issue in *Forsyth* were not based on some unique or esoteric principle of insurance regulation not applicable elsewhere in the law. Rather, both the statutory enactments and the common law remedies reviewed by this Court were based on, and included, common law rules concerning fraud, misrepresentation, false advertising, the duty to negotiate and deal in good faith, and other principles familiar in state laws regulating many areas of commerce. Slip op. at 11-13.

Forsyth thus illustrates that a state may look to generally applicable legal principles when forging the legal tools it will employ to regulate insurance, and that the available raw materials include rules developed and tested under the common law to regulate other forms of contract and commerce. When a state makes the policy choice to adopt a particular rule to regulate insurance, the fact that similar rules, or their animating

principles, are also found elsewhere in the law does not mean that the state's chosen rule is any less a regulation of insurance.

Forsyth also disproves UNUM's remarkable contention that the common law "is not readily amenable to being regarded as a regulatory law." Reply Br. at 4. The Court made no effort to distinguish Nevada's common-law rules from the rest of its framework of insurance regulation. Instead, the Court expressly included Nevada's "common-law remedies" for misconduct by insurance companies as part of the "'State's administrative regime'" of "'state regulation'" designed to "check insurance fraud." Slip op. at 10. Indeed, the Court went out of its way in *Forsyth* to note that the lower courts erred by "inaccurately projecting" Nevada's insurance laws "as allowing for administrative remedies only." Slip op. at 3-4 n. 5. To the contrary, the Court stressed that the Nevada Unfair Insurance Practices Act was "not hermetically sealed; it does not exclude application of other state laws, statutory or decisional." Slip op. at 11. All such laws were, to this Court's mind, equally legitimate parts of the state's regulatory regime.

Surely this is no surprise. The common law regulated the conduct of businesses and individuals for centuries before the first "regulatory" code was adopted or the first administrative agency was created. This approach to common law as often regulatory in nature is entirely consistent with this Court's long-standing recognition that the obligation to pay compensation under state common law is designed to be a potent method for governing conduct and controlling policy.

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IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

No. 97-1868

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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SUPPLEMENTAL BRIEF OF PETITIONER

UNUM Life Insurance Company of America files the following Supplemental Brief to bring to the Court's attention what it believes are significant errors contained in Respondent Ward's Supplemental Brief as to the holding of this Court's recent decision in *Humana Inc. v. Forsyth,* 119 S.Ct. 710 (1999) and its impact on the present case.

Forsyth addressed whether RICO—as applied to an alleged scheme by an insurer to make misrepresentations about the amount of premiums it was charging its customers—would be preempted by the McCarran-Ferguson Act (15 U.S.C. § 1012(b)) as "impairing" Nevada laws regulating the business of insurance. Ward argues that the Nevada laws regulating this practice did not spread risk, were not limited to entities in the insurance industry, and in fact included common law rules of general application. Ward also noted—correctly—that RICO's appli-

cation to the Nevada law would only be at risk if the law regulated "the business of insurance" as defined by McCarran-Ferguson. However, Ward then argues that because this Court decided whether RICO "impaired" these laws it must have adopted a much broader test for the "business of insurance" than was laid down in *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982) and *Group Life & Health Ins. Co. v. Royal Drug*, 440 U.S. 205 (1979) which cases defined the McCarran-Ferguson exemption narrowly and specifically held that the spreading of risk was an "essential" element to the business of insurance.

UNUM submits that this Court could not have been making significant pronouncements about the scope of the business of insurance in the *Forsyth* case, as this issue was not even before the Court. The issue was not briefed by any parties to the lawsuit. In fact, at footnote 13, Respondent Forsyth expressly stated that this is not an issue. (Respondent was the party in whose interest it would have been to argue that McCarran-Ferguson could not preempt the application of RICO to her lawsuit because the state laws in question did not regulate the business of insurance.) Instead, the focus of the briefs of each of the parties, as well as the Opinion of this Court, is entirely on whether application of RICO would "invalidate, impair, or supersede" a Nevada regulatory scheme that was assumed to be a state law regulating the business of insurance. As such, Ward would have this Court accept that an opinion which never addresses the scope ot the business of insurance overruled—by implication—the holdings of *Pireno* and *Royal Drug* on that subject.

Ward also argues that by saying that RICO was not inconsistent with state common law remedies like "bad faith" the opinion also overruled the express holding of *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987) that such laws did not constitute regulation of "the business of insurance." That this sea change in the scope of "the business of insurance" would occur by implication in a case in which that issue was not only not briefed to the

court, but was expressly agreed to be not an issue, is an argument that falls of its own weight.

More significantly, Ward is wrong in his initial assumption, that the state law which the insurer in *Forsyth* argued would be impaired by the application of RICO was not within the accepted definition of the business of insurance. The insurer was accused of a scheme in which it informed its customers that they were paying 20% of medical costs, but that because of alleged discounts the customers were actually paying a substantially larger percentage of the actual cost. In other words, the insurer was accused of informing its customers that it would accept and spread 80% of the risk, while it was really accepting and spreading a smaller percentage. As such, a state law that regulated this practice so obviously spread risk that it is not surprising that application of McCarran-Ferguson was assumed by the parties and this Court.

Respectfully submitted,

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QUESTIONS PRESENTED

1. Whether the "notice-prejudice" rule under California law, which prevents an insurance company from avoiding liability on the basis of an untimely notice or submission of proof unless the insurer has been substantially prejudiced by the delay, is a state law that "regulates insurance" and is thereby saved from preemption by Section 514(b)(2)(A) of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(b)(2)(A) in this case.

2. Whether a state common law rule of agency law, known as the *Elfstrom* rule, under which an employer may, in some circumstances, be deemed to be the agent of the insurance company, "relate[s] to" an ERISA plan within the meaning of ERISA's preemption provision, 29 U.S.C. 1144(a), when applied in an action by a plan participant to recover benefits under ERISA Section 502, 29 U.S.C. 1132.

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BRIEF FOR THE UNITED STATES AS AMICUS CURIAE SUPPORTING PETITIONER IN PART AND SUPPORTING RESPONDENT IN PART

INTEREST OF THE UNITED STATES

This case presents questions concerning the scope of the preemption provision of the Employee Retirement Income Security Act of 1974 (ERISA), 29 U.S.C. 1144(a), as well as the scope of the provision that saves state insurance regulation from ERISA preemption, 29 U.S.C. 1144(b)(2)(A). Because the Secretary of Labor has primary authority for enforcing and administering Title I of ERISA, see 29 U.S.C. 1002(13), 1136(b), the United States has a substantial interest in ensuring that ERISA preemption principles are appropriately applied.

STATEMENT

1. Respondent John E. Ward was president and chief executive officer of Management Analysis Company (MAC) until he resigned in May of 1992. Pet. App. 3a, 27a. During his nine years of employment with MAC, respondent had premiums deducted from his paycheck for long-term disability insurance under a group policy issued by petitioner

UNUM Life Insurance Co. of America to MAC. *Id.* at 28a. This disability policy provides the benefits under MAC's employee welfare plan, which is governed by ERISA. *Id.* at 2a.

In December 1992, respondent was diagnosed as suffering from diabetic neuropathy, which had for some time been causing him severe and disabling leg pain. Pet. App. 3a, 28a. In 1993, he applied for and received an award of state disability benefits, and shortly thereafter, a determination of eligibility for Social Security disability benefits. *Ibid.* Respondent forwarded a copy of that determination to MAC's human resources department to arrange for continuation of his health insurance coverage, but was not notified that he might obtain coverage under the long-term disability plan. *Ibid.*

In April 1994, while cleaning out a safety deposit box, he came across a booklet summarizing the disability plan, at which time he again contacted MAC's human resources department to inquire whether he might be covered. Pet. App. 3a, 28a. He was informed by the company that he was covered and was given an application for long-term disability benefits, which he completed and returned to MAC. MAC completed the employer's portion of the application and forwarded it to petitioner on April 11, 1994. *Id.* at 3a, 28a-29a. Two days later, petitioner denied respondent's claim for benefits as untimely under the terms of the policy, which specifies that written proof of claim be given to petitioner not later than one year and 180 days after the onset of disability. *Id.* at 3a, 4a-5a, 29a, 32a. On July 12, 1994, petitioner affirmed its denial, after respondent requested review of his claim. *Id.* at 3a; see *id.* at 29a (different date).

2. Respondent filed suit against the MAC plan and petitioner under Section 502 of ERISA, 29 U.S.C. 1132, to recover benefits. Pet. App. 77a. Respondent argued that the claim was timely under the *Elfstrom* rule, see *Elfstrom* v. *New York Life Ins. Co.*, 432 P.2d 731 (Cal. 1967), a pre-ERISA state agency principle providing that where an

employer administers an insured group health plan, it acts as the agent of the insurance company. In respondent's view, MAC acted as petitioner's agent for purposes of the disability insurance policy, and the notice respondent gave MAC therefore constituted timely notice of claim to petitioner. The district court rejected that argument on the ground that the *Elfstrom* rule is preempted by ERISA and is not saved as a law that "regulates insurance" under ERISA's insurance savings clause, 29 U.S.C. 1144(b)(2)(A). The court reasoned that the *Elfstrom* rule is not a saved insurance regulation for two reasons: it does not transfer risk, and it is not an integral part of the policy relationship between the insurer and the insured, since California law specifically allows insurance contracts to define the extent of the employer's agency relationship with the insurance company. Pet. App. 30a-31a. The district court therefore granted summary judgment for petitioner, agreeing that the claim for benefits was untimely under the terms of the plan. *Id.* at 32a-33a.

3. The Ninth Circuit reversed, on two grounds. First, although the court agreed that the notice and proof of claim were clearly untimely under the express terms of the plan, Pet. App. 4a-5a, the court nevertheless held that the case should be remanded for further consideration of whether, under California's "notice-prejudice" rule, petitioner suffered actual prejudice from the untimely notice. *Id.* at 6a. The notice-prejudice rule provides that an insurer may not deny a claim as untimely unless it can show actual prejudice resulting from the delay. *Id.* at 5a-6a. In holding that ERISA does not preempt the notice-prejudice rule, the court relied on its recent decision in *Cisneros* v. *UNUM Life Insurance Co. of America*, 134 F.3d 939, 945-947 (9th Cir. 1998), petition for cert. pending, No. 97-1867.

Cisneros held that the California notice-prejudice rule is saved from ERISA preemption as a law "which regulates insurance." 29 U.S.C. 1144(b)(2)(A). Noting that the rule

dictates the terms of the insurance relationship and is specifically and exclusively applicable to insurance contracts, the court concluded in *Cisneros* that the rule is saved because it fits a common-sense understanding of insurance regulation. 134 F.3d at 945, citing *Metropolitan Life Insurance Co.* v. *Massachusetts*, 471 U.S. 724, 740-742 (1985). As this Court had done in *Metropolitan Life*, the *Cisneros* court also looked to the three factors that are used in determining whether a particular state law relates to the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. 1012.[1] The *Cisneros* court concluded that the notice-prejudice rule does not satisfy the first factor because it does not transfer or spread policyholder risk as required by that factor. But, the court held, that "imperfection" is not "dispositive," *Cisneros*, 134 F.3d at 945, because the McCarran-Ferguson criteria are simply factors to be weighed in determining whether a law "regulates insurance," *id.* at 946. Because the notice-prejudice rule creates a mandatory contract term and is applicable only to the insurance industry, the court determined that it clearly meets the other two McCarran-Ferguson factors, and that on balance it "regulates insurance" under Section 514(b)(2)(A) of ERISA. *Id.* at 945-947.

Second, in addition to remanding in light of *Cisneros*, the Ninth Circuit also held that the rule of state agency law announced in *Elfstrom*—that "the employer is the agent of the insurer in performing the duties of administering group

---

[1] The three factors are:

> *[F]irst*, whether the practice has the effect of transferring or spreading the policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

Pilot Life v. *Dedeaux*, 481 U.S. 41, 48-49 (1987) (quoting *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982)).

insurance policies," 432 P.2d at 737; see Pet. App. 9a—is not preempted by ERISA Section 514(a), 29 U.S.C. 1144(a). Pet. App. 22a. The court concluded that the *Elfstrom* rule does not "relate to" employee benefit plans within the meaning of Section 514(a) because it does not govern the structure or administration of employee benefit plans or "create an 'alternative enforcement mechanism.'" *Id.* at 21a-22a (citation omitted). Moreover, reasoning that "[n]othing in [Section] 514(a) empowers a plan fiduciary to extend ERISA's preemptive reach by using policy language that negates agency law principles," the court declined to attach significance to the fact that the policy expressly provided that the employer should not be deemed to be the insurer's agent. *Id.* at 22a-23a. The court left to the district court on remand the question whether MAC in fact acted as an agent in administering petitioner's plan, particularly with respect to the receipt and forwarding of benefit claims. *Id.* at 24a-25a.

SUMMARY OF ARGUMENT

I. The notice-prejudice rule under California law provides that an insurer may not deny benefits by reason of an untimely claim, unless the insurer proves that it has suffered prejudice as a result of the untimeliness. Although that rule "relates to" ERISA plans when it is applied to a claim for benefits under an ERISA plan and therefore falls within the scope of ERISA's basic preemption provision, 29 U.S.C. 514(a), it is not preempted, because it falls within the provision of ERISA that saves from preemption state laws that "regulate[] insurance," 29 U.S.C. 1144(b)(2)(A). This Court has employed a two stage-process for determining whether state laws "regulate[] insurance" under the savings clause. The notice-prejudice rule satisfies the first, "common sense" component, because, as the court of appeals found, the rule is not a generally applicable rule of contract law in California, but is instead specifically directed toward the insurance industry. It also generally satisfies the factors used to deter-

mine the application of the McCarran-Ferguson Act, which constitutes the second component of the ERISA insurance savings clause analysis.

The court of appeals held that the notice-prejudice rule does not satisfy the McCarran-Ferguson "risk spreading" factor, but that, taking the analysis as a whole, it nonetheless qualifies as a law that "regulates insurance" within the meaning of the ERISA savings provision. Although it may be argued that the notice-prejudice rule does spread certain risks, the court of appeals' conclusion that the rule "regulates insurance" is correct in any event.

Petitioner argues that all three McCarran-Ferguson factors must be satisfied in order for a law to be found to "regulate[] insurance." This Court has repeatedly referred to the McCarran-Ferguson factors, however, as "guides" or items "relevant" to the analysis; it has stated that no single factor is determinative; and it has actually applied the factors flexibly. Textual differences between the McCarran-Ferguson Act and the ERISA insurance savings clause, as well as a consideration of the differing legal contexts in which the two Acts operate, establish that, even if the McCarran-Ferguson factors would be applied more rigidly in a case arising under that statute, they should be construed flexibly in the ERISA context.

Petitioner has argued that the court of appeals erred because the notice-prejudice rule creates a new cause of action based on a late-filed claim for benefits, and that it therefore conflicts with ERISA's civil enforcement scheme. That argument is mistaken; respondent has simply brought an action under Section 502(a)(1)(B) of ERISA itself for benefits due, and state insurance law provides a relevant rule of decision in that action. Petitioner's contention may be rejected on that ground alone, without addressing any broader rationale regarding the preemptive effect of Section 502 on causes of action brought directly under a state law that regulates insurance. Consideration of that broader

rationale would present the Court with the question whether it should reconsider part of the rationale of its decision in *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41 (1987), regarding the interaction between Congress's intent to make Section 502 the exclusive remedy for claims under ERISA and its simultaneous intent to save state laws that "regulate[] insurance."

II. The court of appeals erred in holding that the state-law *Elfstrom* rule, under which an employer who carries out agency-like duties under an insurance policy will be treated like an agent of the insurance company, may be applied in this case. When applied to an ERISA plan, the *Elfstrom* rule requires the employer to take on additional legal duties that vary from State to State, thereby regulating the basic services that a plan may provide to its participants and beneficiaries. It therefore "relates to" ERISA plans. The *Elfstrom* rule is not saved by the insurance savings provision, because it appears merely to be an application of quite general principles of agency law in the insurance context. A federal court in a case like this could, however, apply similar agency principles as a matter of federal common law under ERISA.

ARGUMENT

CALIFORNIA'S NOTICE-PREJUDICE RULE IS A LAW THAT "REGULATES INSURANCE" AND IS THEREFORE SAVED FROM PREEMPTION BY 29 U.S.C. 1144(B)(2)(A)

A. The Notice-Prejudice Rule "Relates To" ERISA Plans

1. Under Section 514(a) of ERISA, 29 U.S.C. 1144(a), the provisions of ERISA "shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan." The California notice-prejudice rule does "relate to" ERISA plans. As stated by the court of appeals, the rule provides that "the insurer * * * may not deny benefits by reason of untimely notice or submission of proof

of claim unless the insurer proves that it has suffered actual prejudice because of the delay." Pet. App. 5a-6a. That rule is equivalent to requiring each insurance policy—including those issued to ERISA plans, see 29 U.S.C. 1002(1) (defining "employee welfare benefit plan" under ERISA to apply to plans providing benefit "through the purchase of insurance or otherwise")—to contain a term prohibiting a denial of benefits on untimeliness grounds where prejudice cannot be shown.

In *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724 (1985), this Court addressed an analogous issue regarding the preemption under ERISA of a state law mandating that certain mental health benefits be provided to any state resident who is insured under certain types of policies. The Court held that a mandated benefits law of that kind "relates to" ERISA plans insofar as it is sought to be applied to such plans. 471 U.S. at 739. Neither the fact that the state law was consistent with any substantive provision of the plan, nor the fact that the state law applied widely to individuals and entities other than ERISA plans, was sufficient to remove it from the preemptive force of ERISA's "relates to" language. Accord *New York State Conference of Blue Cross & Blue Shield Plans* v. *Travelers Ins. Co.*, 514 U.S. 645, 663-664 (1995) ("Because the regulated policies [in *Metropolitan Life*] included those bought by employee welfare benefit plans, we recognized that the law 'directly affected' such plans."); *Shaw* v. *Delta Airlines, Inc.*, 463 U.S. 85, 97 (1983) (state disability law "which requires employers to pay employees specific benefits, clearly 'relate[s] to' benefit plans").

The same principle applies here. Although the notice-prejudice rule does not mandate that insurance policies issued to ERISA plans include any particular substantive benefit, its effect is similar to that of the laws at issue in *Metropolitan Life* and *Shaw*, because it in effect requires plans to include particular provisions (in this case, regarding

the enforcement of claim filing deadlines) in their insurance contracts. Indeed, the argument that the state law "relates to" ERISA plans is stronger in this case than in *Metropolitan Life* and *Shaw*, since—unlike the substantive benefits that an insured ERISA plan must offer, as to which ERISA itself is silent—the statute itself contains some provisions regarding claims processing.[2] Accordingly, like the rules at issue in *Metropolitan Life* and *Shaw*, the notice-prejudice rule "mandate[s] employee benefit structures or their administration" when applied to ERISA plans. *New York State Conference of Blue Cross & Blue Shield Plans*, 514 U.S. at 658. It therefore "relates to" such plans.

B. The Notice-Prejudice Rule Is Saved From Preemption By ERISA's Insurance Savings Clause

Under the insurance savings clause of ERISA, Section 514(b)(2)(A), 29 U.S.C. 1144(b)(2)(A), the general "relates to" criterion for preemption is significantly qualified. The insurance savings clause provides that "nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A). By saving such insurance regulation from preemption, ERISA "leaves room for complementary or dual federal and state regulation" of the insurance industry. *John Hancock Mut. Life Ins. Co.* v. *Harris Trust & Sav. Bank*, 510 U.S. 86, 98 (1993). The ultimate question in determining whether a state law is saved from preemption under the insurance savings clause is whether the law "regulates insurance."

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[2] The Department of Labor has issued regulations regarding claims procedures, but they do not address the timing of notice of claims. See 29 C.F.R. Pt. 2560. See also 63 Fed. Reg. 48,390-48,409 (1998) (proposing new, minimum claims-procedure regulations, which, among other things, set shorter time limits for the resolution of claims and establish more extensive disclosure and review requirements).

This Court has employed a two-stage analysis for deciding whether a state law "regulates insurance" in this context. First, the Court undertakes a "common-sense" examination of the state law at issue. *Metropolitan Life*, 471 U.S. at 740. "A common-sense view of the word 'regulates' would lead to the conclusion that in order to regulate insurance, a law must not just have an impact on the insurance industry, but must be specifically directed toward that industry." *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 50 (1987). Second, because a purpose of the insurance savings clause was "to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States," *Metropolitan Life*, 471 U.S. at 744 n.21, the three factors used to determine whether a state law regulates the "business of insurance" within the meaning of the McCarran-Ferguson Act are also relevant to the ERISA determination. See note 1, *supra*.[3]

Under this two-tiered analysis, a state law that mandates benefits to be provided in insurance purchased by an ERISA plan falls within the savings provision and is not preempted. *Metropolitan Life*, 471 U.S. at 746. On the other hand, general state tort or contract law that applies to the insurance industry, but is not specifically directed toward that industry, is not a law regulating insurance that falls within the savings provision and, to the extent it "relate[s] to" a plan, is preempted. *Pilot Life*, 481 U.S. at 50, 57.

1. *The court of appeals correctly held that the notice-prejudice rule, as a matter of "common sense," is directed toward the insurance industry.* The court of appeals in this

[3] A state law that purports to regulate insurance by "deem[ing]" a plan to be an insurance company is outside the savings provision and subject to preemption. 29 U.S.C. 1144(b)(2)(B). As a result of that provision, self-insured plans are generally outside the scope of state insurance regulation. See, *e.g.*, *Metropolitan Life*, 471 U.S. at 747. Because this case does not involve a self-insured plan or an attempt to deem a plan to be an insurance company, this "deemer" clause is not at issue in this case.

case relied on its recent decision in *Cisneros* v. *UNUM Life Insurance Co. of America*, 134 F.3d 939 (9th Cir. 1998), petition for cert. pending, No. 97-1867, to hold that the notice-prejudice rule is saved from preemption by virtue of the ERISA insurance savings provision. In *Cisneros*, the court reasoned that the notice-prejudice rule, "by requiring the insurer to prove prejudice before enforcing proof-of-claim requirements, * * * dictates the terms of the relationship between the insurer and insured and so seems, as a matter of common sense, to 'regulate insurance.'" *Id.* at 945. The court also noted that "[t]he rule is directed specifically at the insurance industry and is applicable only to insurance contracts." *Ibid.* The Ninth Circuit's conclusion in *Cisneros* that the notice-prejudice rule satisfies an ordinary understanding of insurance regulation is correct.[4]

Petitioner belatedly argued in its reply brief at the certiorari stage of this case that the notice-prejudice rule "is nothing more than a basic principle of contract law which applies to *all* contracts, not merely insurance policies." Pet. Reply Br. 5. Assuming that that issue is "fairly included" in the questions presented in the petition, see Sup. Ct. R. 14.1(a), and is therefore properly before the Court, petitioner's new argument should be rejected. Determining whether California's notice-prejudice rule is directed at the insurance industry narrowly, or is instead a "basic principle of contract law" recognized throughout the State's law,

[4] The notice-prejudice rule is not unique to California insurance regulation. As one influential treatise has noted, "there is something approaching a consensus in regard to the general proposition that an insured's coverage should only be lost when the insurer has been prejudiced." Robert E. Keeton & Alan I. Widiss, *Insurance Law: A Guide To Fundamental Principles, Legal Doctrines, and Commercial Practices* § 7.2, at 763 (1988). Indeed, if the rule were not saved by the insurance savings clause, the question would arise as to whether the rule should be adopted as a matter of federal common law under ERISA itself. See, *e.g.*, *Pilot Life*, 481 U.S. at 56.

requires an analysis of the law of California. Petitioner offers no reason to disturb the conclusion of the court of appeals, which is presumed to be familiar with the law of the States in its circuit, that the notice-prejudice rule under California law is directed specifically at the insurance industry. See *Sheridan* v. *United States*, 487 U.S. 392, 401-402 (1988); *Runyon* v. *McCrary*, 427 U.S. 160, 181 (1976); *Huddleston* v. *Dwyer*, 322 U.S. 232, 237 (1944).

In any event, our survey of California law reveals no cases where the state courts apply the notice-prejudice rule as such outside the insurance area. Nor is this surprising, given that the rule is stated in terms of prejudice to an "insurer" resulting from untimeliness of notice. See *Shell Oil Co.* v. *Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 760 (Ct. App. 1993) ("California law is settled that a defense based on an insured's failure to give timely notice requires the insurer to prove that it suffered substantial prejudice."). Thus, even if petitioner were correct in viewing the notice-prejudice rule (perhaps like much insurance regulation) as having its roots in established common law contract doctrine, or more broadly as being a species of harmless error doctrine, we agree with the Ninth and District of Columbia Circuits that, as it now exists, the rule of notice-prejudice "applies only to insurers." *O'Connor* v. *UNUM Life Ins. Co. of Am.*, 146 F.3d 959, 964 (D.C. Cir. 1998); compare *Security Life Ins. Co. of Am.* v. *Meyling*, 146 F.3d 1184, 1189 (9th Cir. 1998) (California insurance code provision allowing rescission in the event of material misrepresentation merely codifies the common law remedy of rescission and is not a regulation of insurance).[5]

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[5] We note that state common law created by the decisions of state courts, such as the notice-prejudice rule, fits ERISA's literal definition of state law. 29 U.S.C. 1144(c)(1) ("[t]he term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law").

2. *The McCarran-Ferguson Act factors also suggest that the California notice-prejudice rule is a law that "regulates insurance" under the ERISA savings clause.* In its prior decision in *Cisneros*, upon which the court relied in this case, the court of appeals considered the application of the McCarran-Ferguson Act factors to the California notice-prejudice rule. The court held that the notice-prejudice rule clearly satisfies two of the factors, concluding that the rule is "an integral part of the policy relationship between the insurer and the insured" and that it "is limited to entities within the insurance industry." See *Cisneros*, 134 F.3d at 946. Those conclusions are correct. By "effectively creat-[ing] a mandatory contract term" that requires the insurer to prove prejudice before enforcing a timeliness-of-claim provision, the notice-prejudice rule "dictates the terms of the relationship between the insurer and the insured, and consequently, is integral to that relationship." *Ibid.* In addition, as discussed above, the notice-prejudice rule appears to be specifically tailored to the insurance industry and applies only in that context. The primary dispute in this case, then, concerns the remaining McCarran-Ferguson factor—whether the notice-prejudice rule "has the effect of transferring or spreading a policyholder's risk." *Metropolitan Life*, 471 U.S. at 743.

a. The *Cisneros* court held that the notice-prejudice rule does not satisfy the McCarran-Ferguson "risk spreading" criterion. The court held that that criterion "refers to the risk of injury for which the insurance company contractually agreed to compensate the insured." 134 F.3d at 945-946. The court stated that, although "[t]he notice-prejudice rule does shift the risk of lost coverage as a result of late submission of proof," it "does not alter the allocation of risk for which the parties initially contracted, namely the risk of lost income from long-term disability." *Id.* at 946.

In our view, although the distinction the court of appeals attempted to draw between different types of risk spreading

finds substantial support in the case law,[6] it is ultimately unsatisfactory. Insofar as the notice-prejudice rule shifts the risk of late notice and stale evidence from the insured to the insurance company in some instances, it has the effect of raising premiums and spreading risk among policyholders. See *United States Dep't of Treasury* v. *Fabe*, 508 U.S. 491, 503-504 (1993) (in holding that the actual performance of a contract constitutes the "business of insurance" within the meaning of the McCarran-Ferguson Act, the Court notes that "[w]ithout performance of the terms of the insurance policy, there is no risk transfer at all."). Therefore, the notice-prejudice rule could, in our view, be found to satisfy the McCarran-Ferguson "risk spreading" factor.[7]

b. The Court need not, however, determine the soundness of the court of appeals' conclusion that the notice-prejudice rule does not spread risk under the McCarran-

[6] See *Davies* v. *Centennial Life Ins. Co.*, 128 F.3d 934, 941 (6th Cir. 1997); *Tingle* v. *Pacific Mut. Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993); *DeBruyne* v. *Equitable Life Assurance Soc'y of the United States*, 920 F.2d 457, 469 (7th Cir. 1990); *Smith* v. *Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 569 n.9 (11th Cir.), cert. denied, 513 U.S. 808 (1994); cf. *O'Connor*, 146 F.3d at 962 note (noting that because policyholder conceded the point, it had no occasion to decide whether the notice-prejudice rule transfers or spreads policyholder risk).

[7] Although the court of appeals attempted to rely on this Court's decision in *Metropolitan Life* to support its distinction between "the risk for which the parties originally contracted" and the risk of late notice and stale evidence addressed by the notice-prejudice rule, 134 F.3d at 946, that reliance was misplaced. The Court in *Metropolitan Life* held that a state law mandating the inclusion of certain mental health benefits in certain types of insurance policies tended to spread risks under the McCarran-Ferguson Act test. Just as in this case, however, the risk that was spread by the state rule—the risk of mental illness—was not a risk "for which the parties initially contracted," in the Ninth Circuit's phrase; the parties in *Metropolitan Life* specifically contracted only to spread other kinds of health risk. Nonetheless, the state law at issue required the parties to spread an additional risk, and it was therefore found to satisfy the McCarran-Ferguson "risk spreading" criterion.

Ferguson factors. Even if the notice-prejudice rule does not spread the kind of risk addressed by the McCarran-Ferguson factors, the fact that it does not is not fatal to the contention that the rule "regulates insurance" within the meaning of the ERISA savings clause. That is because, as the Ninth Circuit correctly held, "the McCarran-Ferguson factors are simply relevant considerations or guideposts, not separate essential elements of a three-part test that must each be satisfied for a law to escape preemption." *Cisneros*, 134 F.3d at 946.[8]

Initially, this Court itself has made it clear that the McCarran-Ferguson criteria were not intended to introduce a rigid three-part test under that Act. Although the Court stated in *Group Life & Health Insurance Co.* v. *Royal Drug*

[8] The Ninth Circuit's view is in line with that of the District of Columbia and Sixth Circuits, *O'Connor*, 146 F.3d at 963; *Davies*, 128 F.3d at 940; cf. *Soniat* v. *Travelers Ins. Co.*, 538 So. 2d 210, 214-215 (La. 1989) (holding policy-cancellation provision saved under common-sense approach without resort to *Pireno* factors), while the Fifth Circuit is the only circuit to have directly held that all three factors are essential. *CIGNA Healthplan of La., Inc.* v. *Louisiana ex rel. Ieyoub*, 82 F.3d 642, 650 (5th Cir.) ("[I]f a statute fails * * * to satisfy any one element of the three-factor *Metropolitan Life* test, then the statute is not exempt from preemption by the ERISA insurance savings clause."), cert. denied, 519 U.S. 964 (1996); accord *Tingle*, 996 F.2d at 108 (holding statute preempted that "fails to satisfy at least one prong of the three part *Metropolitan Life* test"). Other courts have reached varying results that appear to depend on a more flexible analysis, not a rigid rule requiring state laws to satisfy each of the McCarran-Ferguson criteria to come within the ERISA insurance savings clause. See, *e.g.*, *Brewer* v. *Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990) (common law rule not saved because it failed two factors), cert. denied, 501 U.S. 1238 (1991); *Howard* v. *Gleason Corp.*, 901 F.2d 1154, 1158-1159 (2d Cir. 1990) (statutory provision not saved because it failed to meet common sense test and two factors); *Kelley* v. *Sears, Roebuck & Co.*, 882 F.2d 453, 456 (10th Cir. 1989) (statute not saved because it failed to meet two of three factors); *Anschultz* v. *Connecticut Gen. Life Ins. Co.*, 850 F.2d 1467, 1469 (11th Cir. 1988) (state law that failed to meet two of McCarran-Ferguson factors is not saved).

Co., 440 U.S. 205, 211-212 (1979), that risk-spreading is an "indispensable characteristic of insurance," it does not follow that regulation of the business of insurance always directly involves the regulation of risk-spreading, either under the McCarran-Ferguson Act itself or under ERISA. Indeed, since its initial articulation of the three criteria in *Royal Drug*, the Court has been consistent in disavowing any attempt to use them as a rigid three-part test. That has been true both in cases directly applying the McCarran-Ferguson Act, such as *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982) ("None of these criteria is necessarily determinative in itself."), and in cases applying the ERISA insurance savings clause, such as *Pilot Life*, 481 U.S. at 48, 49 (referring to the factors as "guide[s]" or "considerations [to be] weighed") and *Metropolitan Life*, 471 U.S. at 743 ("three criteria *relevant to* determining whether a particular practice falls within * * * the 'business of insurance'") (emphasis added). Indeed, in *FMC Corp.* v. *Holliday*, 498 U.S. 52, 61 (1990), the Court found a state anti-subrogation provision to be an insurance law without any reference to the *Pireno* factors.

The Court's analysis in *Pilot Life* also indicates that the insurance savings clause calls for a more flexible approach. After determining that the state law in that case met neither a "common-sense" understanding of insurance nor the first McCarran-Ferguson factor, because it did not spread risk, 481 U.S. at 50, the Court proceeded to address the other two factors as well. *Id.* at 50-51. That additional analysis would not have been necessary if petitioner were correct that a regulation must qualify under all three prongs.

Furthermore, the textual differences between the McCarran-Ferguson Act and the ERISA insurance savings clause suggest a somewhat broader scope for the latter. The ERISA insurance savings clause saves any law that "regulates insurance," 29 U.S.C. 1144(b)(2)(A)—a somewhat broader formulation than the McCarran-Ferguson Act's

reference to laws "enacted * * * for the purpose of regulating the business of insurance." 15 U.S.C. 1012(b). Consequently, the stricter approach that may be appropriate in McCarran-Ferguson Act cases to distinguish between the "business of insurance," which displaces federal antitrust and securities laws, and the "business of insurance companies," which may be subject to those laws, see *SEC* v. *National Sec., Inc.*, 393 U.S. 453, 459 (1969), would not have controlling significance in the ERISA context.

Finally, the differing legal contexts in which the McCarran-Ferguson Act and the ERISA insurance savings clause operate suggest that, even if a somewhat stricter application of the McCarran-Ferguson criteria were appropriate elsewhere, a more flexible approach should be applied in the ERISA context. The McCarran-Ferguson Act was primarily directed toward drawing a line between a well-developed federal regulatory regime under the federal antitrust laws and the equally well-developed state regulation of insurance; accordingly, a conclusion that the McCarran-Ferguson Act does not apply does not prohibit all regulation, but merely has the effect of subjecting an insurer to the federal regime. By contrast, a conclusion that a state law is not a law that "regulates insurance" under the ERISA insurance savings clause frequently has the opposite effect: it displaces a settled state scheme that has been found necessary to protect consumers and beneficiaries of insurance policies, without subjecting insurers to any corresponding scheme of substantive regulation under federal law. The Congress that enacted ERISA was deeply concerned with the basic goal of protecting the rights of plan participants and beneficiaries. A too-rigid application of principles drawn from McCarran-Ferguson Act cases in the context of the ERISA insurance savings clause could easily result in depriving ERISA participants and beneficiaries—whom Congress sought to protect—of needed consumer protections without providing any alternative.

C. The Notice-Prejudice Rule Does Not Conflict With ERISA'S Civil Enforcement Provisions

Petitioner contends that, even if the notice-prejudice rule would be saved under the insurance savings clause, it is nonetheless preempted because it conflicts with a substantive provision of ERISA and with the written terms of the ERISA plan in this case. Petitioner relies on *Pilot Life*, which it reads as having held that "ERISA would bar these [state] causes of action [for improper claims processing and failure to pay benefits]—even if the 'saving' clause were applicable—because they conflict with one of ERISA's substantive provisions, its exclusive civil enforcement scheme in [Section] 502(a)." Pet. 23, citing *Pilot Life*, 481 U.S. at 51-57. Petitioner is wrong, however, in its basic premise.

1. Petitioner's premise that a claim that conflicts with the written terms of a plan could not be a claim for benefits under Section 502(a) of ERISA, 29 U.S.C. 1132(a)—and therefore must be a state cause of action for improper claims processing or failure to pay benefits—is mistaken. In this case, the notice-prejudice rule is relevant not because it creates a separate state cause of action, but because it supplies a legal rule of decision to be applied in an ordinary action under Section 502(a)(1)(B), 29 U.S.C. 1132(a)(1)(B), "to recover benefits due * * * under the terms of the plan." In this respect, this case is analogous to *Metropolitan Life*, which held a state substantive law mandating certain insurance benefits to be saved. It is also analogous to *FMC Corp.*, in which the Court concluded that a state anti-subrogation rule would be saved, notwithstanding that the state rule affected the plan's payment of benefits. Analytically, there is no reasonable distinction to be made among a state mandatory-insurance-benefit law, an anti-subrogation rule, and a notice-prejudice requirement. Each kind of mandate must be viewed, as a matter of state insurance law, as incorporated into the terms of the insurance purchased by

plans in that State; none of these state mandates "conflict[s] with a substantive provision of ERISA." *Pilot Life*, 481 U.S. at 57 (referring to *Metropolitan Life*); cf. *John Hancock*, 510 U.S. at 99 n.9 ("[n]o decision of this Court has applied the saving clause to supersede a provision of ERISA itself").

In short, as the Court concluded in *FMC Corp.*, 498 U.S. at 64, "if a plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts." Petitioner's argument to the contrary would virtually "read[] the saving clause out of ERISA entirely," *Metropolitan Life*, 471 U.S. at 741, since even the mandated benefits law at issue in *Metropolitan Life* would not be saved under such analysis.[9]

2. For the reasons stated in point 1, petitioner's contention that applying the notice-prejudice rule would conflict with Section 502 of ERISA should be rejected on the ground that this is an action for benefits under Section 502; applying the notice-prejudice rule as a rule of decision on the merits in a suit under Section 502 therefore in no way conflicts with any intent by Congress to make Section 502 the exclusive source of a cause of action. Petitioner's contention may be

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[9] Contrary to petitioner's contention (Pet. 25), the notice-prejudice rule does not conflict with the requirement in Section 503 of ERISA, 29 U.S.C. 1133, that plans must provide notice and the opportunity for review of denied claims, 29 U.S.C. 1133, or with the Secretary's regulation providing that "[a] claim is filed when the requirements of a reasonable claim filing procedure * * * have been met," 29 C.F.R. 2560.503-1(c) and (d). Rather, the notice-prejudice rule complements ERISA and the Secretary's regulation by providing a longer time to file a claim in the context of insured plans, if the insurer will not suffer prejudice thereby. Nor is petitioner correct in asserting (Pet. 25) that application of the notice-prejudice rule, contrary to a plan's express terms, conflicts with the statutory requirements that fiduciaries follow the written terms of the plan and pay benefits in accordance with those terms. 29 U.S.C. 1104(a)(1)(D), 1132(a)(1)(B). Those provisions could not reasonably be read to require fiduciaries to follow a plan's terms in contravention of applicable federal or state law.

rejected on that ground alone. If the Court does so, there will be no occasion for it to revisit the difficult issue of whether ERISA preempts a state law cause of action or remedy independent of Section 502, even where the state law in question "regulates insurance" within the meaning of the insurance savings provision. Resolving the interaction between Congress's intent to make Section 502 an exclusive remedy for claims under ERISA and its simultaneous intent to save state laws that "regulate[] insurance" would present the Court with the question whether it should reconsider part of the rationale of its decision in *Pilot Life* v. *Dedeaux*. As we explain below, there may be substantial reasons for the Court to do so, but there is no occasion for the Court to address that issue in this case.

We recognize that *Pilot Life* has been read to preclude even state law causes of action arising under laws that "regulate[] insurance."[10] That portion of *Pilot Life*'s rationale is, however, in significant tension with the text of the insurance savings provision and was unnecessary to *Pilot Life*'s holding that the law at issue there was not in any event an insurance regulation within the meaning of that provision.[11]

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[10] Most lower courts to have confronted the issue have concluded, like petitioner here, that *Pilot Life* requires the preemption of claims for benefits or remedies under state-law provisions that otherwise clearly constitute insurance law. See *Kanne* v. *Connecticut Gen. Life Ins. Co.*, 867 F.2d 489, 493-494 (9th Cir. 1988), cert. denied, 492 U.S. 906 (1989); *In re Life Ins. Co. of N. Am.*, 857 F.2d 1190, 1194-1195 (8th Cir. 1988) (citing district court cases); but see *Franklin H. Williams Ins. Trust* v. *Travelers Ins. Co.*, 50 F.3d 144, 151 (2d Cir. 1995).

[11] A number of bills were introduced in the Second Session of the 105th Congress that would have altered ERISA's preemption provisions to permit additional actions or remedies by participants and beneficiaries in health care plans. See, *e.g.*, H.R. 3605, S. 1890, S. 1891, S. 2330, S. 2416 (1998).

In *Pilot Life*, the Court considered whether ERISA preempted state common law tort and contract causes of action for bad faith processing of a claim for benefits by an insurer. Analyzing the state common law creating the cause of action at issue, the court initially concluded that (a) under a "common sense" view, the cause of action was rooted in general principles of Mississippi tort and contract law and was not "specifically directed toward th[e insurance] industry," 481 U.S. at 50; and (b) it "at most meets one of the three criteria used to identify the 'business of insurance' under the McCarran-Ferguson Act," *id.* at 51. Those holdings were sound, and they provided ample basis to conclude that the state law did not come within the ERISA insurance savings clause. The Court's holding in *Pilot Life* that the state law was preempted was therefore correct.

In a succeeding portion of the *Pilot Life* opinion, however, the Court—consistent with the position of the Solicitor General in a brief filed at the petition stage of the case (see 481 U.S. at 52; see note 14, *infra*)—went on to consider whether its conclusion that the state law was preempted was supported by the express provision in ERISA of a cause of action by a participant or beneficiary for plan benefits under Section 502(a)(1)(B), on the theory that that cause of action is exclusive of any others, such as a cause of action arising under state law. The Court concluded that it was, see 481 U.S. at 52-57, stating that "[t]he policy choices reflected in the inclusion of certain remedies and the exclusion of others under the federal scheme would be completely undermined if ERISA-plan participants and beneficiaries were free to obtain remedies under state law that Congress rejected in ERISA." 481 U.S. at 54. In that portion of its opinion, the Court did not advert to the text of the insurance savings clause. Instead, it relied heavily on Congress's intent with respect to Section 502, evident from the legislative history of ERISA, to federalize ERISA remedies in the same way that Section 301(a) of the Labor Management Relations Act

(LMRA), 29 U.S.C. 185(a), had federalized remedies for violations of collective bargaining agreements. See 481 U.S. at 54-56.

We do not question that reasoning in *Pilot Life* as a general matter. Unquestionably, "Congress intended § 502(a) to be the exclusive remedy *for rights guaranteed under ERISA*." *Ingersoll-Rand Co.* v. *McClendon*, 498 U.S. 133, 144 (1990) (emphasis added); *Mertens* v. *Hewitt Assocs.*, 508 U.S. 248, 253-254 (1993) (because of comprehensive enforcement scheme, Court will not infer additional *federal* causes of action). And it is certainly true that, outside the context of state laws that "regulate insurance" within the meaning of the ERISA insurance savings clause, that exclusivity of the Section 502 civil enforcement provisions also appropriately informs the Court's understanding of the scope of ERISA preemption where a plaintiff brings a cause of action under state law that "relates to" an ERISA plan. See, *e.g.*, *Ingersoll-Rand*, 498 U.S. at 142. Congress, in short, clearly intended the remedial provisions of ERISA to be exclusive of any generally applicable state-law remedies related to ERISA plans. H.R. Conf. Rep. No. 1280, 93d Cong., 2d Sess. 327 (1974); see also *Metropolitan Life Ins. Co.* v. *Taylor*, 481 U.S. 58, 62-64, 66 (1987); *Franchise Tax Bd.* v. *Construction Laborers Vacation Trust*, 463 U.S. 1, 24 (1983).

It does not follow, however, that ERISA Section 502 should inform the preemption inquiry to the same extent with respect to a state-law cause of action or remedy that specifically "regulates insurance" as it does with respect to one of general applicability. In that situation, Congress has saved state substantive law, and it is not clear why Congress would have wanted to foreclose all access to state-created remedies or sanctions to enforce that substantive law, see, *e.g.*, *Metropolitan Life*, 471 U.S. at 734 (suit by state Attorney General against insurer of ERISA plans to enforce provision of state insurance law), especially where the causes

of action provided under Section 502 itself are not suited to that purpose.[12]

The savings clause states that "*nothing in this subchapter* shall be *construed* to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. 1144(b)(2)(A) (emphasis added). "[T]his subchapter" includes Section 502, which has been construed to provide exclusive remedies under ERISA, as well as the preemption provision itself, Section 514(a). Accordingly, the savings clause by its terms directs that nothing in Section 502, which concerns causes of action and remedies under ERISA, shall be "construed" to relieve or exempt any person from "any law" of a State that regulates insurance. Thus, the insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated-benefits laws and other prescriptive measures that do so.

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[12] During the congressional debate on ERISA, substantive and enforcement provisions of law were linked by Senator Williams with reference to both the rule of preemption and its exceptions. Senator Williams observed that "with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for Federal regulations." 120 Cong. Rec. 29,933 (1974), quoted in *Shaw*, 463 U.S. at 99. To the extent ERISA preempts the field for federal regulation, see *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A.*, 519 U.S. 316, 335-336 (1997) (Scalia, J., concurring), it follows that both state substantive law and the measures to enforce that state law are preempted. But where ERISA does *not* preempt the field—here, because the insurance "exception" in Section 514(b) applies—there is force to the corresponding proposition that both state substantive insurance law and at least some enforcement measures necessary to make that substantive law effective are saved. Surely, for example, ERISA's saving of "any generally applicable criminal law of a State," 29 U.S.C. 1144(b)(4), authorizes the State to bring a criminal prosecution, not merely to have its substantive law applied in a suit brought under ERISA.

This Court gave effect to the facially unrestricted scope of the insurance savings clause in *Metropolitan Life*, when it "declin[ed] to impose any limitation on the saving clause beyond those Congress imposed in the clause itself and in the 'deemer clause' which modifies it," and concluded that "[i]f a state law 'regulates insurance,' as mandated-benefit laws do, it is not preempted." 471 U.S. at 746; cf. *Pilot Life*, 481 U.S. at 56-57 (*Metropolitan Life* clearly "rejected an interpretation of the [insurance] saving clause * * * that saved from preemption 'only state regulations unrelated to the substantive provisions of ERISA'").[13] In addition, the force of the savings provision's express terms is reinforced by the Court's frequent recognition—particularly in recent cases—that ERISA's preemption provisions must be read against the background of the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress." *Travelers*, 514 U.S. at 655; see also *De Buono* v. *NYSA-ILA Med. & Clinical Servs. Fund*, 520 U.S. 806, 813 n.8 (1997); *California Div. of Labor Standards Enforcement* v. *Dillingham Construction, N.A.*, 519 U.S. 316, 325 (1997).

[13] Of course, notwithstanding the savings clause, an insurance law that conflicts with a provision of ERISA itself is preempted by virtue of the Supremacy Clause. See *John Hancock*, 510 U.S. at 99-100. Although the insurance savings clause "leaves room for complementary or dual federal and state regulation," ERISA "calls for federal supremacy when the two regimes cannot be harmonized or accommodated." *Id.* at 98. "[I]n the case of a direct conflict, federal supremacy principles require that state law yield." *Id.* at 100. Such conflict preemption occurs "where compliance with both federal and state regulations is a physical impossibility, or where state law stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." See *Boggs* v. *Boggs*, 520 U.S. 833, 834 (1997), citing *Gade* v. *National Solid Wastes Management Ass'n*, 505 U.S. 88, 98 (1992). There is no indication, for example, that Congress believed that judicial enforcement of state insurance law by a participant or beneficiary would in all circumstances conflict with the purposes of the provision in Section 502(a)(1)(B) for a participant to bring an action for benefits under the plan itself.

Furthermore, insofar as the significance of Section 502 for the preemption inquiry derives from Congress's intent to pattern suits under Section 502 on suits under Section 301 of the LMRA, that intent does not bear directly on the preemption of a state-law cause of action or remedy that "regulates insurance." That is because LMRA Section 301 does not contain any statutory exception analogous to ERISA's insurance savings provision. While Section 301 is no doubt highly instructive in cases in which the scope of ERISA's broad "relates to" preemption provision is at issue, Congress's enactment of the insurance savings provision suggests that it did not intend that parallel to be controlling where the state law, while within the scope of the preemption provision, *also* falls within the terms of insurance savings clause. Thus, the general background of Section 502(a) discussed in *Pilot Life* does not in itself require that a state law that "regulates insurance," and so comes within the terms of the savings clause, is nevertheless preempted if it provides a state- law cause of action or remedy.[14]

[14] In a brief filed in response to the Court's invitation at the petition stage in *Pilot Life*, we argued "that since Congress intended the procedures it established in Section 502 to be the exclusive procedures for enforcing claims for benefits due under employee benefit plans, the states are barred from establishing alternative procedures." Brief for the United States as Amicus Curiae at 19, *Pilot Life Ins. Co.* v. *Dedeaux*, No. 85-1043. We adhere to that conclusion in circumstances like those that were before the Court in *Pilot Life*, where a beneficiary invoked a general "state common law cause of action," *ibid.*, to obtain benefits under a plan, as well as other remedies. For the reasons given in the text, however, the exclusive nature of Section 502 may come into conflict with, rather than reinforce, the terms of the insurance savings clause where the participant or beneficiary (like the State Attorney General in *Metropolitan Life*, see 471 U.S. at 734) invokes a cause of action under state law that "regulates insurance"—*e.g.*, to enforce a specific provision of state insurance law that could not be enforced in a suit under Section 502. Insofar as our discussion

II. THE *ELFSTROM* RULE DOES "RELATE TO" ERISA PLANS WHEN IT IS APPLIED TO THEM, AND IT IS THEREFORE PREEMPTED

The court of appeals erred in concluding that the *Elfstrom* rule, as a general principle of state agency law, does not unduly interfere with plan administration and thus does not "relate to" an employee benefit plan in this instance. To the contrary, the *Elfstrom* rule "relate[s] to" plans within the meaning of Section 514(a), because, when applied in the context of deciding a claim for benefits under ERISA, it could directly interfere with the goal of national uniformity in plan administration.[15]

The *Elfstrom* rule, which pre-dates ERISA and which provides that "the employer is the agent of the insurer in performing the duties of administering group insurance policies," *Elfstrom* v. *New York Life Ins. Co.*, 432 P.2d 731, 737 (Cal. 1967), may not explicitly refer to or be dependent on the existence of an ERISA plan. See *Ingersoll-Rand*, 498 U.S. at 139. But the application of the *Elfstrom* rule to claims for benefits—like those advanced by respondent in

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in the text departs from the views we expressed at the certiorari stage in *Pilot Life*, it is worth noting that our submissions concerning ERISA preemption —like the Court's analyses—have been refined in light of the benefit of significant experience with ERISA preemption in the intervening 12 years. Specifically, it is now clear that preemption analysis must begin with the presumption that Congress did not intend to preempt state law, particularly in "fields of traditional state regulation." *Travelers*, 514 U.S. at 654-655. That presumption is particularly strong in the area of state insurance regulation, whose continued validity and application to ERISA plans Congress expressly provided for.

[15] In the same way, the notice-prejudice rule also "relate[s] to" the plan. Unlike the *Elfstrom* rule, however, notice-prejudice is a law regulating insurance that is saved from preemption, and any "disuniformities" that result from the application of the notice-prejudice rule "are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life*, 471 U.S. at 747.

this case—does have a direct effect on plan administration. In effect, it forces the employer, as plan administrator, to assume a role, with attendant legal duties and consequences, that it has not undertaken voluntarily. Compare *De Buono*, 520 U.S. at 815-816 (economic impact alone insufficient to "relate to" plan); *Travelers*, 514 U.S. at 662, 668 (same). That is especially troubling because, as petitioner points out (Pet. 28), state agency law varies from state to state, and it could easily be the case that one multi-state plan would be subject to contradictory agency principles depending on what state law is applied. See, *e.g.*, *First Nat'l Bank* v. *Nationwide Ins. Co.*, 278 S.E.2d 507, 514-515 (N.C. 1981) (North Carolina law "establishes that the employer-master policyholder is not ordinarily the agent of the insurer"). Moreover, unlike a garnishment law like that at issue in *Mackey* v. *Lanier Collection Agency & Service*, 486 U.S. 825, 831-832 (1988), the effect on administration is not only substantial, but central and pervasive; it affects not merely the plan's bookkeeping obligations regarding to whom benefits checks must be sent, but also regulates the basic services that a plan may or must provide to its participants and beneficiaries. Accordingly, application of the *Elfstrom* rule to claims for benefits like that of respondent is contrary to ERISA's goal of uniform federal administration of employee benefit plans and thereby "relates to" ERISA plans.[16]

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[16] Although the issue apparently was presented to the district court, see Pet. App. 30a-31a, no party appears to be contending that the *Elfstrom* rule, although formulated in the context of insurance, is a state law that "regulates insurance" for purposes of the ERISA insurance savings clause. In our view, the *Elfstrom* rule is not a law that "regulates insurance," both because it is not specifically directed at insurance and for the additional reasons discussed by the district court, see Pet. App. 31a. The court of appeals described as "sound" and "comport[ing] with [the Ninth Circuit's] prior determination of the same issue" a formulation that makes quite clear that the rule is not law directed specifically at insurers, but is instead an application of general principles of agency law: "as the em-

Although we believe that the state-law *Elfstrom* rule is preempted, we are not suggesting that general agency principles, or indeed contract or trust principles, have no place in deciding an ERISA benefits claim. In this respect, the analogy to LMRA Section 301 is instructive. As in cases under that Act and in the absence of pertinent regulations issued by the Department of Labor, see 29 U.S.C. 1133, the federal courts are required to develop a uniform "federal common law of rights and obligations," *Pilot Life*, 481 U.S. at 56, concerning the circumstances under which ERISA plans will be held to have acted as agents of insurance companies. See, *e.g.*, *Allis-Chalmers Corp.* v. *Lueck*, 471 U.S. 202, 210 (1985)("[A] suit * * * alleging a violation of a provision of a labor contract must be brought under § 301 and be resolved by reference to federal law."). In developing that federal common law, the courts certainly can look to state-law principles. *Lyman Lumber Co.* v. *Hill*, 877 F.2d 692, 693 (8th Cir. 1989). But, by subjecting plans to a federal common law standard, the statutory goal of consistent application in a multi-state setting can be achieved. See *Shaw*, 463 U.S. at 105. Given their roots in general principles of agency law, rules similar to the *Elfstrom* rule appear to be widespread in state law. See Pet. App. 12a (citing cases). Thus, on remand the courts below should consider whether the *Elfstrom* rule, or something like it, applies to the circumstances of this case as a matter of federal, not California, common law.[17]

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ployer assumes responsibility for more administrative or sales functions which are customarily performed by an insurer, a question of fact will arise as to the agency relationship between the insurer and the employer." Pet. App. 13a n.6 (quoting *Paulson* v. *Western Life Ins. Co.*, 636 P.2d, 935, 939 (Or. 1981)). Cf. Pet. App. 24a (noting that "[t]he question ultimately for the district court under *Elfstrom* becomes whether MAC acted for UNUM and under UNUM's control in receiving and forwarding long-term disability claims").

[17] See, *e.g.*, *Security Life Ins. Co. of Am.* v. *Meyling*, 146 F.3d 1184, 1191 (9th Cir. 1998) (holding that rescission is an available remedy under the federal common law of ERISA); *McClure* v. *Life Ins. Co. of N. Am.*, 84 F.3d 1129, 1135 (9th Cir. 1996) (adopting "reasonable expectations" doctrine as a matter of federal common law to aid in interpretation of ERISA insurance policies); *City of Hope Nat'l Med. Ctr.* v. *HealthPlus, Inc.*, 156 F.3d 223, 228-229 (1st Cir. 1998) (applying federal common law principles of assignment in context of ERISA claim); *Ford* v. *Uniroyal Pension Plan*, 154 F.3d 613, 619 (6th Cir. 1998) (refusing to apply state law when calculating prejudgment interest award in context of successful ERISA benefits claim, but instead applying federal common law principles); *Moriarty* v. *Glueckert Funeral Home, Ltd.*, 155 F.3d 859, 865-867 (7th Cir. 1998) (in case arising under ERISA and LMRA, court applied federal common law of agency in determining whether member of multi-employer association was bound by particular provision of collective bargaining agreement concerning contributions to employee benefit plan).

CONCLUSION

The judgment of the Ninth Circuit with respect to the applicability of California's notice-prejudice rule should be affirmed. The court's judgment with respect to the applicability of the *Elfstrom* rule, however, should be reversed.

Respectfully submitted.

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In The

Supreme Court of the United States

October Term, 1998

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

JOHN E. WARD,

Respondent.

On Writ Of *Certiorari* To The United States Court Of Appeals For The Ninth Circuit

MOTION FOR LEAVE TO FILE BRIEF FOR THE ASSOCIATION OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANIES AS *AMICUS CURIAE* AND BRIEF AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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MOTION FOR LEAVE TO FILE BRIEF FOR THE ASSOCIATION OF CALIFORNIA LIFE AND HEALTH INSURANCE COMPANIES AS *AMICUS CURIAE* AND BRIEF AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

Pursuant to Rule 37.3 of the Rules of this Court, the Association of California Life and Health Insurance Companies ("ACLHIC") respectfully requests leave to file the accompanying brief as *amicus curiae* in support of petitioner. Counsel for petitioner has consented to the filing of this *amicus curiae* brief. Counsel for respondent has not consented to the filing of this brief.

ACLHIC is a nonprofit association whose members are domestic California life and health insurance companies and foreign life and health insurance companies which do business in California. One of the primary purposes of ACLHIC is to represent the interests of its members and their policyholders in substantial public policy matters which affect them. ACLHIC has participated as *amicus curiae* in other federal cases for this purpose. ACLHIC has a duty to promote the solvency and efficiency of its members and the soundness of the products they issue.

In the instant case, ACLHIC has a substantial interest in insuring the efficient administration of life, disability and health insurance policies issued to employee benefit plans subject to the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. Sections 1001, *et seq.* The inefficient interposition in the administration of such plans of disparate state common law rules of statewide, general application, such as the California notice-prejudice rule, is contrary to the express terms of ERISA and to

the prior decisions of this Court. The application of such rules to ERISA plans generally will result in inefficient state-by-state benefit determinations, to the detriment of participants, beneficiaries, plan sponsors and service providers such as the members of ACLHIC. Moreover, the particular common law doctrine in question here – the California notice-prejudice rule – would unpredictably extend liability for tardy claims, prevent the reliable closing of annual accounting periods and provide disparate benefits to plan beneficiaries who reside in different states.

ACLHIC is familiar with the questions involved in the case and the scope of their presentation. ACLHIC believes that additional argument should be presented on one aspect of the legal analysis of the decision below. While petitioner has fully analyzed and briefed the legal issues presented, additional briefing by ACLHIC will assist the Court by demonstrating a significant error of law in the decision below.

It is therefore respectfully requested that the motion of ACLHIC for leave to file the attached brief as *amicus curiae* be granted.

Respectfully submitted,

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INTEREST OF THE AMICUS

The Association of California Life and Health Insurance Companies ("ACLHIC") is a nonprofit association whose members are domestic California life and health insurance companies and foreign life and health insurance companies which do business in California.[1] Its interest in the issues presented by the petition is substantial and directly affects its members for the reasons set forth in the foregoing motion for leave to file this brief. Petitioner has consented to the filing of this brief. Respondent has not consented.

The Ninth Circuit's decision in this case conflicts with *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-50 (1987), because, without analysis or explanation, it applies a common law doctrine of general application as if it were a law specifically directed at the insurance industry. The result is to invalidate ERISA benefit plan rules requiring the timely submission of claims and to complicate the administration and increase the expense of such plans, to the ultimate detriment of the plans and their participants.

ACLHIC's members and the plans they serve, as well as the plans' beneficiaries, have a substantial interest in the timely submission and adjudication of benefit claims. Contrary to the orderly administration of benefit plans,

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[1] Pursuant to Rule 37.6, *amicus* ACLHIC states that no counsel for a party has written this brief in whole or in part and that no person or entity, other than *amicus*, or its counsel, has made a monetary contribution to the preparation or submission of this brief.

permitting late claims by application of the California notice-prejudice rule would open up closed accounting periods and render unreliable the financial results for such closed periods. Benefit plans and their insurers alike will necessarily be obliged to alter their financial planning because the results for a given period will always be in doubt and subject to revision by the resuscitation of untimely claims. Moreover, applying such judge-made doctrines to overrule the clear terms of written benefit plans will undermine the clarity and certainty of the plans in contravention of the expressed intention of Congress.

REASONS FOR REVERSAL

I. "Notice-Prejudice" is a Rule of General Application.

In this action, the Ninth Circuit correctly held that California's common law notice-prejudice rule is within the scope of ERISA preemption as a state law which "related to" an employee benefit plan. ERISA Section 514(a), 29 U.S.C. Section 1144(a). The Ninth Circuit erred, however, in its conclusion that the notice-prejudice rule is a state law regulating insurance which could be "saved" from ERISA preemption under ERISA Section 514(b)(2)(a), 29 U.S.C. Section 1144(b)(2)(a). In this decision, the Ninth Circuit followed its earlier and similarly erroneous decision in *Cisneros v. UNUM Life Ins. Co. of America*, 134 F.3d 939 (9th Cir. 1998).

In *Cisneros*, the Ninth Circuit analyzed *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 (1985), and *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 48-50 (1987),

acknowledging that a state law is only saved from ERISA preemption if the law is "specifically directed" at the insurance industry and if it "regulates insurance", 134 F.3d at 944-945.

The Ninth Circuit failed, however, correctly to apply the common sense test of *Dedeaux* in reaching the erroneous conclusion that such a law must be "specifically directed" at the insurance industry. Indeed, the *Metropolitan Life* decision explained that, to be part of the business of insurance, the practice in question must be "limited to entities within the insurance industry". *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. at 743. *Metropolitan Life* in turn relied upon *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), where the Court refused to accord McCarran-Ferguson protection to a claim adjudication practice, in part because it involved parties outside the insurance industry. Since the goal of Congress was, this Court said, "to protect 'intra-industry cooperation' in the underwriting of risks", a practice which involved non-insurance entities "can hardly be said to lie at the center of that legislative concern". *Pireno*, 458 U.S. at 133.

On examination, it will readily be seen that the notice-prejudice rule is neither "specifically directed" at the insurance industry nor "limited to entities within the insurance industry". Instead, the notice-prejudice rule is one of common application to a wide variety of situations and parties outside the insurance industry, like the practice addressed in *Pireno, supra*.

The notice-prejudice rule simply requires that prejudice must result before failure to give a required notice will work a forfeiture. In short, harmless breaches will be

ignored. A broad expression of this commonplace doctrine may be found in the Restatement (Second) of Contracts, Section 229, as follows:

> To the extent that the non-occurrence of a condition would cause disproportionate forfeiture, a court may excuse the non-occurrence of that condition unless its occurrence was a material part of the agreed exchange.

Indeed, the requirement that prejudice must result before a failure to perform a contractual condition or to give a required notice will work a forfeiture is a common doctrine in the law of California and has been applied in a wide variety of civil, criminal, family and commercial matters. *See People v. Carrera*, 49 Cal. 3d 291, 261 Cal. Rptr. 348, 777 P.2d 121 (1989), *cert. denied*, 495 U.S. 911 (1990) (failure to give notice of testimony in aggravation of a capital murder sentence harmless where defendant was not prejudiced by lack of notice); *Conservatorship of Rand*, 49 Cal. App. 4th 835, 57 Cal. Rptr. 2d 119 (1996) (failure to give notice of citation to proposed conservatee harmless where no prejudice resulted); *People v. Howard*, 44 Cal. 3d 375, 243 Cal. Rptr. 842, 749 P.2d 279, *cert. denied*, 488 U.S. 871 (1988) (untimely notice of evidence to be used in penalty phase of capital murder prosecution harmless where no prejudice shown); *In re David C.*, 152 Cal. App. 3d 1189, 20 Cal. Rptr. 115 (1984) (failure to give adequate notice of termination of custody of minor child harmless where no prejudice shown); *Industrial Asphalt, Inc. v. Garrett Corp.*, 180 Cal. App. 3d 1001, 226 Cal. Rptr. 17 (1986) (failure to serve statutory notice of mechanic's lien claim ineffective to defeat lien where no prejudice resulted).

Indeed, if anything, notice-prejudice is merely a branch of the broad doctrine of harmless error: in every manner of case and circumstance, excepting only jurisdictional defects, courts disregard irregularities and informalities which do not result in substantial prejudice. Thus, California courts apply the harmless error doctrine to excuse the failure timely to post jury fees where no prejudice is proven. *Johnson-Stovall v. Superior Court*, 17 Cal. App. 4th 808, 21 Cal. Rptr. 2d 494 (1993). Likewise, California ignores the failure to give proper and advisable jury instructions concerning criminal negligence where the failure would not have prejudiced the defendant, given a jury finding of guilt of first degree premeditated and deliberate murder. *People v. Mayfield*, 14 Cal. 4th 668, 60 Cal. Rptr. 2d 1, 928 P.2d 485, *cert. denied*, 118 S. Ct. 116 (1997). The failure to make timely service of a civil action has similarly been excused absent a finding of prejudice. *Putnam v. Clague*, 3 Cal. App. 4th 542, 5 Cal. Rptr. 2d 25 (1992). Likewise, informalities in the proof of service of documents are ignored where actual service occurred and no prejudice resulted. *Lum v. Mission Inn Foundation, Inc.*, 180 Cal. App. 3d 967, 226 Cal. Rptr. 22 (1986).

This Court, too, has applied the notice-prejudice rule, and in contexts far removed from the insurance industry. *See Pioneer Investment Services v. Brunswick Associates Ltd. Partnership*, 507 U.S. 380 (1993) (tardy filing of bankruptcy proofs of claim excused where debtor was not prejudiced by delay); *Jersey Shore State Bank v. U.S.*, 479 U.S. 442 (1986) (third party lender not unfairly prejudiced by government failure to give notice of tax claim).

In *Cisneros, supra,* the Ninth Circuit assumed without analysis that the notice-prejudice rule is directed specifically at the insurance industry. The only authority cited by the Ninth Circuit for the conclusion that the notice-prejudice rule is directed specifically at the insurance industry and is applicable only to insurance contracts is *Pilot Life Ins. Co. v. Dedeaux,* 481 U.S. 41, 50 (1987). *Dedeaux,* of course, only sets forth the standard that to be regarded as a law which regulates insurance, it must not only have an impact on the insurance industry but must be specifically directed toward that industry. *Dedeaux,* by itself, lends no support for the conclusion that this particular rule is specifically directed at the insurance industry. And while the Ninth Circuit cited *Dedeaux,* it failed to pursue the careful analytical approach of *Dedeaux* in delving in detail into the jurisprudential history of the doctrine in question, which in *Dedeaux* was the availability of punitive damages under Mississippi law. In *Dedeaux,* this Court concluded that:

> "Even though the Mississippi Supreme Court has identified its law of bad faith with the insurance industry, the roots of this law are firmly planted in the general principles of Mississippi tort and contract law. Any breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law." 481 U.S. 41 at 50.

The same is manifestly true here. The California courts have identified the notice-prejudice law with the insurance industry, but its roots are firmly planted in the general principles of California jurisprudence, both civil and criminal. The doctrine of excuse of minor breach under the rubric "notice-prejudice" has been identified

with and applied to the insurance industry, but the self-same doctrine has also been applied in a myriad of non-insurance contexts, just as the punitive damages law of Mississippi had been applied to many non-insurers. The Ninth Circuit did not attempt, nor could it, to show that the common law doctrine to excuse minor, non-prejudicial contract breaches is one specifically directed toward that industry.

Cases applying the notice-prejudice doctrine to the insurance industry may be found and are cited in the Ninth Circuit opinion in *Cisneros* (*Shell Oil Co. v. Swiss Ins. Co.,* 12 Cal. App. 4th 715, 15 Cal. Rptr. 2d 815, 845 (1993); and *Clemmer v. Hartford Ins. Co.,* 22 Cal. 3d 865, 151 Cal. Rptr. 285, 587 P.2d 1098, 1106-1107 (1978)), but such a demonstration is unavailing to answer the essential inquiry of whether the rule is specifically directed toward the insurance industry. What must instead be demonstrated is that the doctrine in question applies only to insurers and not to non-insurance entities. It was evidence that the claims practice in *Pireno, supra,* involved non-insurers which, in part, disqualified Union Labor Life from McCarran-Ferguson protection and it was evidence that the Mississippi punitive damage law applied to non-insurers which required its preemption in *Dedeaux, supra.* Citing instances where a rule of general applicability has been applied to the insurance industry does not make that rule specifically directed at that industry any more than the previous application of punitive damage concepts to insurers made Mississippi's punitive damage law one directed specifically at the insurance industry. The Ninth Circuit's reliance on cases showing that notice-prejudice applies to the insurance

industry was misplaced because the same do nothing to establish that the rule is limited to that industry. As abundantly demonstrated above, there is no such limitation in California or elsewhere. Notice-prejudice is instead commonly applied to a wide variety of parties and legal settings.

II. The Application of Notice-Prejudice Undermines the Requirement of Adherence to Written Plan Documents and Opens the Door to Disparate Regulation.

Judge Posner of the Seventh Circuit cogently observed that "[one] of ERISA's purposes is to protect the financial integrity of pension and welfare plans by confining benefits to the terms of the plans as written. . . ." *Pohl v. National Benefits Consultants, Inc.*, 956 F.2d 126 (7th Cir. 1992). The adoption of notice-prejudice, no less than the recognition of the oral coverage representations of which Judge Posner wrote, would undermine this purpose of ERISA and impair the financial integrity of pension and welfare plans. This is all the more true because, as the Ninth Circuit recognized in the predecessor to this case, *Cisneros v. UNUM Life Ins. Co., supra*, 134 F.3d at 947, there is no uniformity in the methods of applying the notice-prejudice doctrines of the various states. Plan administrators and their insurers, then, will be tasked to award different benefits to different plan beneficiaries, all in ways unpredictable from the terms of the plan document. Further, because the accounting period for any plan can never be considered closed if the financial results may be reopened for late claims which have been revived by notice-prejudice, plans and their insurers will be

unable accurately to determine the costs for a given period and the appropriate rate adjustments for ensuing ones.

In addition, the faulty reasoning of the Ninth Circuit's decision will permit disparate state-by-state rulings on topics far beyond notice-prejudice. Any common law doctrine which has been applied to the insurance industry may, by application of the Ninth Circuit's "analysis", be regarded as one directed at the insurance industry and saved from preemption.[2]

The inevitable result of the Ninth Circuit approach is to save from preemption laws *sometimes* applied to the insurance industry, rather than applied *only* to the insurance industry. This logic will open the floodgate of disparate state regulation and usher in the "patchwork scheme of regulation" which ERISA's broad preemption provision was enacted to eliminate. *See Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1, 10 (1987). Instead of attaining ERISA's manifest goal of increased efficiency and reduced costs, plans and plan administrators will be required to pay late claims and, more importantly, to administer plans separately according to the law of each state. This will in turn reduce the affordability of benefit plans and increase the likelihood that benefits will be withdrawn or not offered at all.

---

[2] It is ironic that the Ninth Circuit's approach would demonstrate that the Mississippi law of punitive damages is specifically directed at the insurance industry – after all, it has been repeatedly applied in insurance cases. *Dedeaux, supra*, is a complete answer to this fallacy.

CONCLUSION

In enacting ERISA, Congress intended to encourage the provision of benefits in a cost-effective and efficient manner. As an integral part of that effort, Congress broadly preempted state law. This Court has enforced the determination of Congress that only laws specifically directed at the insurance industry may escape preemption. The law in question here is not so restricted but has been applied in many non-insurance cases and contexts. More importantly, the decision below was reached not by showing that the notice-prejudice doctrine had been applied only to the insurance industry but only that it had sometimes been so applied. To so lower the preemption bar would mean that any law ever applied to an insurer would escape preemption. The entire salutary purpose of Congress in adopting preemption would effectively be thwarted and plans would henceforth be subject to a scheme of patchwork, state-by-state regulation.

The Ninth Circuit's decision should be reversed to advance the goals of Congress to promote efficient, nationwide standards of plan administration and to preserve the availability of plan benefits for plan beneficiaries.

Respectfully submitted,

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No. 97 - 1868

In The
Supreme Court of the United States
October Term, 1998

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,
v.
JOHN E. WARD,
Respondent.

On Writ of Certiorari to
The United States Court of Appeals For The Ninth Circuit

BRIEF OF AMICI CURIAE ASSOCIATION OF PRIVATE PENSION AND WELFARE PLANS, CHAMBER OF COMMERCE OF THE UNITED STATES, NATIONAL ASSOCIATION OF MANUFACTURERS, AND NEW ENGLAND LEGAL FOUNDATION IN SUPPORT OF PETITIONER

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QUESTIONS PRESENTED

1. Whether the United States Court of Appeals for the Ninth Circuit erred in holding that California's "notice-prejudice" common law rule is not preempted by ERISA when the rule "relates to" ERISA plans and does not spread the risk of loss.

2. Whether the United States Court of Appeals for the Ninth Circuit erred in holding that California's common law Elfstrom rule does not "relate to" an ERISA plan and is, therefore, not preempted by ERISA when the rule alters the written terms of the plan and creates fiduciary duties which are contrary to those set forth in ERISA and which the parties did not agree to create.

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INTEREST OF AMICI CURIAE[1]

The Association of Private Pension and Welfare Plans ("APPWP") is a broad-based, non-profit trade association

1. Pursuant to Supreme Court Rule 37.6, counsel for *amici* states that neither counsel for Petitioner nor Respondent authored this brief in whole or in part and no person or entity other than *amici* made a monetary contribution to the preparation or submission of the brief.

founded in 1967 to protect and foster the growth of the private employer-sponsored employee benefit plan system in the United States. The members of the APPWP include both small and large employer sponsors (including many Fortune 500 companies) of employee benefit plans, as well as numerous plan support organizations, such as consulting and actuarial firms, investment firms, banks, insurers and other professional benefit organizations. Collectively, its more than 240 members sponsor or administer plans covering more than 100 million plan participants. This broad-based membership provides the APPWP with substantial expertise and experience with respect to the entire spectrum of issues relating to all types of benefit plans. The APPWP has filed *amicus curiae* briefs in numerous cases involving important issues for the employee benefit plan community.

The Chamber of Commerce of the United States ("the Chamber") is the world's largest business federation. The Chamber represents an underlying membership of more than three million businesses and organizations of every size, in every sector and region. An important function of the Chamber is to represent the interests of its members in the federal courts in cases addressing issues of widespread concern to the American business community. The Chamber has participated as *amicus curiae* in several hundred cases before the Court, including numerous ERISA cases. See, e.g., California Div. of Labor Standards v. Dillingham Construction, N.A., Inc., _ U.S. _, 117 S. Ct. 832 (1997); Lockheed Corp. v. Spink, 517 U.S. 882 (1996); Varity Corp. v. Howe, 516 U.S. 489 (1996); District of Columbia v. Greater Washington Bd. of Trade, 506 U.S. 125 (1992); Ingersoll-Rand Co. v. McClendon, 498 U.S. 133 (1990); and FMC Corp. v. Holliday, 498 U.S. 52 (1990).

The National Association of Manufacturers ("the NAM") is the nation's oldest and largest broad-based industrial

trade association. Its nearly 14,000 member companies and subsidiaries, including 10,000 small manufacturers, employ approximately eighty-five percent of all manufacturing workers and produce over eighty percent of the nation's manufactured goods. More than 158,000 additional businesses are affiliated with the NAM through its Associations Council and National Industrial Council.

The New England Legal Foundation ("NELF"), a non-profit, public interest law firm, was incorporated in 1977. Its membership consists of corporations, individuals, and others who believe in promoting balanced economic growth for New England, protecting the free enterprise system and defending economic rights. NELF's more than 130 members and supporters include a cross-section of large and small corporations from all parts of New England and the United States. NELF has regularly appeared in state and federal court, as party or counsel, in cases raising issues of general economic significance to the business community. See, e.g., Lockheed Corp. v. Spink, 517 U.S. 882 (1996); Reich v. Southern New England Telecommunications Corp., 121 F.3d 58 (2d Cir. 1997); Cigna Health Plan of Louisiana v. Louisiana, 82 F.3d 642 (5th Cir. 1996).

Amici are concerned that, if allowed to stand, the decision below will create and foster conflicting federal and state regulation of ERISA plans to the great detriment of those employers and their employees who rely on the availability of group insurance plans to provide employee health and welfare benefits.

Pursuant to Supreme Court Rule 37.2, counsel for *amici* have secured written consent for the filing of this brief from counsel for Petitioner and Respondent.

STATEMENT OF THE CASE

Amici accept and adopt the Statement of the Case contained in the Brief of the Petitioner UNUM Life Insurance Company of America ("UNUM").

SUMMARY OF ARGUMENT

The Ninth Circuit erroneously concluded that two California common law rules that are inconsistent with ERISA and contrary to the express terms of an ERISA plan are not preempted. Application of these common law rules to claims for benefits by California plan participants destroys the uniformity of plan administration that Congress intended and prohibits multi-state employers from providing the same benefits to all plan participants. The added burdens that the Ninth Circuit recognized its holding imposed on plan administrators may lead to the reduction of benefits, a result that Congress sought to avoid by enacting ERISA's preemption provision.

California's "notice-prejudice" rule relates to ERISA plans, as the Ninth Circuit correctly recognized. The Ninth Circuit, however, erred in holding that this common law rule was saved from preempted as a law which regulates insurance. The "notice-prejudice" rule does not spread the risk of loss and conflicts with substantive provisions of ERISA. Application of the "notice-prejudice" rule alters the express terms of ERISA plans and would result in the payment of benefits to California plan participants that are precluded by the express terms of the plan. The Ninth Circuit's holding supplants ERISA's enforcement provisions and is, therefore, preempted.

Similarly, California's Elfstrom rule, which holds that an employer acts as the agent of the insurer when it undertakes administrative tasks necessary to effectuate insurance for its employees, relates to ERISA plans because it alters the terms of those plans. The Elfstrom rule alters the allocation of fiduciary responsibilities set forth in ERISA plans and creates respondeat superior liability that ERISA itself does not impose. Because it conflicts with ERISA and destroys the uniformity of plan administration that Congress intended to achieve, California's Elfstrom rule is preempted.

ARGUMENT

I. THE NINTH CIRCUIT ERRED IN IMPOSING TWO CALIFORNIA COMMON LAW RULES ON THE ADMINISTRATION OF ERISA PLANS THEREBY DISRUPTING THE UNIFORMITY OF REGULATION THAT ERISA SOUGHT TO ENSURE.

At issue is whether ERISA, 29 U.S.C. §§ 1001 et seq., preempts two California common law rules which are inconsistent with the express terms of a written ERISA plan and which, if applied as envisioned by the United States Court of Appeals for the Ninth Circuit, would result in the provision of disability benefits that the plan would prohibit. If the decision below is not reversed, plan participants who fail to follow the claims initiation and processing procedures set forth in their benefits plans will be encouraged to turn to state law to attempt to alter or nullify those terms and to supplant ERISA's enforcement provisions through the application of state law. The resulting chaos and increased costs of insured plans which will be created by conflicting state and federal regulation of ERISA plans was precisely what ERISA preemption attempted

to avoid.

This Court has repeatedly emphasized that Congress designed ERISA's preemption provision, 29 U.S.C. §1144(a), to "eliminat[e] the threat of conflicting and inconsistent State and local regulation" of ERISA plans. Fort Halifax Packing Co. v. Coyne, 482 U.S. 1, 9 (1987), *quoting* 120 Cong. Rec. 29197 (1974) (remarks of Representative Dent). See, e.g., Shaw v. Delta Air Lines, Inc., 463 U. S. 85, 105 (1983). This Court has also repeatedly explained why Congress believed it was necessary to eliminate "conflicting and inconsistent State and local regulation":

> The most efficient way to meet [the responsibilities of administering an employee benefit plan] is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some states but not in others; *to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.*

Fort Halifax Packing Co. 482 U.S. at 9 (emphasis added).

Yet under the Ninth Circuit's decision, California participants in an employer's multi-state plan will be entitled to disability benefits that participants in other states, with different

common law rules regarding notice and imputed agency, will not be entitled to receive. As a result, multi-state employers will be precluded from offering uniform benefits to their employees throughout the country. This Court has recognized that ERISA attempted to avoid placing employers in such an untenable position:

> To offset the additional expenses [necessarily incurred by complying with conflicting state laws], the employer presumably would reduce wages or eliminate those benefits not required by any State. Another means by which the employer could retain its uniform nationwide plan would be by eliminating classes of benefits that are subject to state requirements with which the employer is unwilling to comply. *ERISA's comprehensive pre-emption of state law was meant to minimize this sort of interference with the administration of employee benefit plans.*

Shaw, 463 U.S. at 105 n.25 (emphasis added). Achieving uniformity is so central to ERISA's goals, that this Court has "not hesitated to enforce ERISA's pre-emption provision where state law created the *prospect that an employer's administrative scheme would be subject to conflicting requirements."* Fort Halifax Packing Co., 482 U.S. at 10 (emphasis added). This Court should not hesitate to strike down the conflicting claims-processing rules which the Ninth Circuit sanctioned, "fully cognizant of the complications and extra burdens" that at least one of these common law rules would create for insurers and employers. Cisneros v. UNUM Life Ins. Co. of America , 134 F.3d 939, 947 (9th Cir. 1998), *petition for cert. filed*, 67 U.S.L.W. 3035 (U.S. May 20, 1998) (No. 97-1867). "Otherwise, the inefficiencies created could work to the detriment of plan beneficiaries." Ingersoll-Rand Co. v.

McClendon, 498 U.S. 133, 142 (1990).

As demonstrated in the following sections, ERISA preempts both California common law rules.

II. CALIFORNIA'S "NOTICE PREJUDICE" RULE WHICH "RELATES TO" AND DISRUPTS ERISA PLANS IS PREEMPTED.

John Ward, former president and CEO of Management Analysis Company ("MAC"), applied for benefits under a long-term disability insurance policy (the "Plan") sponsored by MAC and issued by UNUM. Ward v. Management Analysis Co. Employee Disability Benefit Plan, 135 F.3d 1276, 1278 (9th Cir. 1998). UNUM denied the claim as untimely. Id. Under the terms of the Plan, Mr. Ward was required to give UNUM written notice of his claim no later than 18 months after the onset of his disability. Id. at 1280. Although Mr. Ward claimed that his disability first began on May 5, 1992, while he was still employed by MAC, he did not submit any notice of claim to UNUM until April 11, 1994 — more than 23 months after the alleged onset of the illness and more than 5 months after the proof-of-claim deadline. Id.

Mr. Ward sued UNUM claiming that California's "notice-prejudice rule" precluded UNUM from denying his claim as untimely. Id. at 1279. He also claimed that, under California's Elfstrom rule, MAC should be considered UNUM's agent and, therefore, his alleged notice to MAC of his disability constituted notice to UNUM. Id. at 1281. The U.S. District Court for the Southern District of California granted UNUM's motion for summary judgment, holding that the two common law rules were preempted by ERISA. Id. at 1279.

The Ninth Circuit reversed. Id. at 1289.

The Ninth Circuit held that, under the express terms of the Plan, "timely submission of proof [of claim] is a condition precedent to payment of benefits." Ward, 135 F.3d at 1280. Mr. Ward did not give UNUM written notice of his claim within the time limits set forth in the Plan. The Ninth Circuit excused his failure to comply with the Plan's terms by applying California's "notice-prejudice" common law rule. Under the Ninth Circuit's formulation of the California rule, "the insurer of an ERISA benefit plan may not deny benefits by reason of untimely notice or submission of proof of claim unless the insurer proves it suffered actual prejudice because of the delay."[2] Id.

The Ward court relied on its reasoning in a companion case, Cisneros v. UNUM Life Ins. Co. of America, 134 F.3d 939 (9th 1998), *petition for cert. filed*, 67 U.S.L.W. 3035 (U.S. May 20, 1998) (No. 97-1867), to hold that the "notice-prejudice" rule is not preempted by ERISA. While recognizing that the "notice-prejudice" rule "relates to" an employee benefit plan, the Ninth Circuit held that it fell within ERISA's "savings clause" and was, therefore, "exempt from preemption." Id. at 944.

ERISA's "savings clause" exempts from preemption any state law which "regulates insurance." 29 U.S.C. § 1144 (b)(2)(A). To determine whether a state law "regulates

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2. "Prejudice is not presumed from the delay alone, . . . and the insurer must show *actual* prejudice, not the mere possibility of prejudice, in order to avoid liability." Cisneros v. UNUM Life Ins. Co. of America, 134 F.3d 939, 944 (1998) (citation omitted; emphasis in original).

insurance," the Court considers "a common-sense view of the matter," Metropolitan Life Ins. Co. v. Massachusetts, 471 U.S. 724, 740 (1985), and the three criteria developed under the McCarran-Ferguson Act concerning the meaning of the phrase "business of insurance":

> [F]irst, whether the practice has the effect of transferring or spreading a policyholder's risk; second, whether the practice is an integral part of the policy relationship between the insurer and the insured; and third, whether the practice is limited to entities in the insurance industry.

Id. at 743, *quoting* Union Labor Life Ins. Co. V. Pireno, 458 U.S. 119, 129 (1982) (emphasis omitted). The Ninth Circuit concluded that, although the "notice-prejudice" rule does not spread the policyholder's risk of loss, it satisfies the two other McCarran-Ferguson criteria: it is directed at the insurance industry and forms "an integral part of the relationship between the insurer and the insured." Cisneros, 134 F.3d at 946-47. The Ninth Circuit held that a law need not satisfy all three McCarran-Ferguson criteria to be preempted. Id. at 946. Moreover, it rejected the view that spreading the risk of loss is indispensable to a finding that a state law regulates insurance. Id.

As Petitioner UNUM's Brief demonstrates, to be saved from preemption a state law must satisfy all three McCarran-Ferguson criteria and California's "notice-prejudice" rule does not. *Amici* would add a practical argument to UNUM's legal argument. If a state law may be saved from preemption when it is not a law that spreads the risk of loss, it will be virtually impossible for Plan Administrators and claims processors to predict with any degree of certainty whether a state law which clearly relates to an ERISA plan is preempted. Such a result

would fly in the face of Congress's intent:

> The uniformity of decision which the Act is designed to foster will help administrators, fiduciaries and participants to predict the legality of proposed actions without the necessity of reference to varying state laws.

H.R. Rep. No. 93-533 at 12 (1973), reprinted in 2 Senate Comm. on Labor and Public Welfare, Legislative History of the Employee Retirement Income Security Act of 1974, 94th Cong., 2d Sess. 2359 (Comm. Print 1976) ("Legislative History"). The Ninth Circuit's analysis, if affirmed, would not only require "reference to varying state laws," it would greatly reduce the ability of plan administrators "to predict the legality of proposed actions." Indeed, because "notice-prejudice" rules are replacing the traditional rule in some states, see Barry R. Ostrafer & Thomas R. Newman, Handbook on Insurance Coverage Disputes § 4.02 [c][2] (9th ed. 1998), "predicting the legality of proposed actions" will be impossible.

There is a more fundamental reason for preemption here. A state law that conflicts with any of ERISA's substantive provisions is preempted. Pilot Life Ins. Co. v. Dedeaux, 481 U.S. 41, 51-57 (1987). The Ninth Circuit recognized that there was a direct conflict between ERISA and the notice-prejudice rule, noting that the rule caused "a plan's written terms [to be] altered," caused "complications and extra burdens" on plan administration, and made the plan "more difficult to administer" because the rule "differ[s] markedly in various states." Id. at 947. The Court nonetheless held that the common law rule was not preempted.

These conflicts alone require a holding that the "notice-prejudice" rule is preempted. ERISA requires fiduciaries to

discharge their duties "in accordance with the documents and instruments governing the plan," 29 U.S.C. § 1104 (a)(1)(D). It does not provide that fiduciaries discharge their duties "in accordance with the documents and instruments governing the plans as those instruments may be altered by the varying common law of the fifty states." In addition, ERISA permits "a participant or beneficiary" to "recover benefits due to him under the terms of his plan." 29 U.S.C. § 1132 (a)(1)(B). No benefits were "due" Mr. Ward "under the terms of his plan." The "notice-prejudice" rule supplants this enforcement provision by entitling Mr. Ward to benefits that are not "due" under the Plan.

Moreover, while ERISA does not dictate any particular claims processing procedure, the Department of Labor's regulations set forth some minimum requirements. As to claims initiation and processing, the regulations provide, in pertinent part:

> Every employee benefit plan shall establish and maintain reasonable claims procedures.
>
> (1) A claims procedure *will be deemed reasonable* only if it:
>
> . . .
>
> (ii) Is described in the summary plan description . . . .
>
> (iii) Does not contain any provision, and is not administered in a way, which unduly inhibits or hampers the initiation or processing of plan claims . . . .

29 C.F.R. § 2560.503-1(b)(1)(ii) & (iii) (emphasis added). The claim initiation and processing procedures are set forth in the Plan Summary, see Petition at 42a-47a, and the 18-month

period to file a proof of claim does not "unduly hamper" the initiation of a claim. Indeed, Mr. Ward did not claim that the time limits set forth in the written Plan inhibited the initiation of his disability claim. Had he done so, the Ninth Circuit would have been required to look to federal common law to determine if the time limit was unreasonable, as Congress intended. See Pilot Life Ins. Co., 481 U.S. at 56, *quoting* 120 Cong. Rec. 29933 (remarks of Senator Javits) ("[i]t is also intended that a body of Federal substantive law be developed by the courts to deal with issues involving rights and obligations under private welfare and pension plans"). Indeed, as this Court noted, Congress determined that the development of federal common law was preferable to permitting state law to supplant ERISA's enforcement provisions:

> The expectations that a federal common law of rights and obligations under ERISA-regulated plans would develop, indeed, the entire comparison of ERISA's § 502(a) to § 301 of the LMRA, would make little sense if the remedies available to ERISA participants and beneficiaries under § 502(a) could be supplemented or supplanted by varying state laws.

Id. The Ninth Circuit erroneously ignored this instruction and permitted the "notice-prejudice" rule to supplant ERISA's enforcement provisions.

Finally, as noted above, permitting the "notice-prejudice" rule to revive a claim barred by the written terms of an ERISA plan conflicts with the purpose of ERISA "to minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." Ingersoll-Rand Co., 498 U.S. at 142.

For this reason as well, California's "notice-prejudice" rule is preempted.

III. THE *ELFSTROM* RULE "RELATES TO" ERISA PLANS AND IS PREEMPED.

More than fifty years ago, this Court explained the typical relationship between the employer and the insurer of an insured employee benefit plan:

> Employers regard group insurance not only as protection at low cost for their employees but also as advantageous to themselves in that it makes for loyalty, lessens turn-over and the like. When procuring the policy, obtaining applications of employees, taking payroll deduction orders, reporting changes in the insured group, paying premiums and generally in doing whatever may serve to obtain and keep the insurance in force, employers act not as agents of the insurer but for themselves.

Bozeman v. Connecticut General Life Ins. Co., 301 U.S. 196, 204-05 (1937). California's Elfstrom rule[3] takes a contrary view and deems the employer the agent of the insurer when the employer administers an insured plan. As demonstrated below, the Elfstrom rule conflicts with ERISA and is preempted.

Congress permitted co-fiduciaries of ERISA plans to

3. Elfstrom v. New York Life Ins. Co., 37 Cal.2d 503, 432 P.2d 731, 63 Cal Rptr. 35 (1967).

"allocate responsibilities among themselves and, by so doing, generally limit their liability to the extent of their specified duties." S. Rep. 93-127 at 34 (1973), reprinted in 1 Legislative History 620. Accordingly, ERISA provides:

> (1) the instrument under which a plan is maintained may expressly provide for procedures (A) for allocating fiduciary responsibilities (other than trustee responsibilities) among named fiduciaries . . . .

29 U.S.C. §1105(c). ERISA insulates co-fiduciaries from liability for the acts or omissions of other co-fiduciaries unless the co-fiduciary:

> participates knowingly in, or knowingly undertakes to conceal, an act or omission of such other fiduciary, knowing such act or omission is a breach;
>
> . . . by his failure to comply with section 404(a)(1)[4] in the administration of his specific responsibilities which give rise to his status as a fiduciary, he has enabled such other fiduciary to commit a breach; or
>
> . . . has knowledge of a breach by such other fiduciary, unless he makes reasonable efforts under the circumstances to remedy the breach.

4. Section 404 (a) of ERISA, 29 U.S.C. § 1104(a)(1) requires a plan fiduciary to discharge his duties with respect to the plan solely in the interest of the participants and beneficiaries."

29 U.S.C. §1105(a). ERISA thus imposes personal liability on fiduciaries; it does not create respondeat superior liability.

Consistent with these provisions, MAC was designated as the Plan Sponsor and Plan Administrator. 29 U.S.C. § 1002 (16)(A) & (B). MAC's duties under the Plan included providing UNUM "information relative to employees . . . who qualify to become insured; . . . whose amounts of insurance change; and/or . . . whose insurance terminates." Petition at 42a. The Plan also provided that MAC "acts on its own behalf or as agent of the employee" and not UNUM's agent absent "written authorization."[5] Id. at 44a. Under the terms of the Plan, UNUM was responsible for receiving, processing, and paying claims under the terms of the Plan. See id at 42a-44a. The Plan unambiguously required participants to provide UNUM, not MAC, "written notice of claim" within the time limits set forth in the Plan. Id. at 42a.

Mr. Ward did not provide written notice of his claim to UNUM during the time limits set forth in the Plan. Rather, he contended that MAC became aware of his disability and could be considered UNUM's agent pursuant to California's Elfstrom rule for purposes of determining whether notice was timely. Under the Elfstrom rule "the employer is the agent of the insurer in performing the duties of administering group. . . policies." Bass v. John Hancock Mutual Life Ins. Co., 10 Cal.3d 792, 518 P.2d 1147, 1150, 112 Cal. Rptr. 195, 198 (1974). According to the Ninth Circuit, the Elfstrom rule may make MAC an agent of UNUM for the purpose of receiving

5. The Plan provides: "For purposes of this policy, the policyholder acts on its own behalf or as agent of the employee. Under no circumstances will the policyholder be deemed the agent of the Company without a written authorization." Petition at 44a.

notice notwithstanding the express language in the Policy that MAC is not UNUM's agent and notwithstanding the contrary allocation of fiduciary responsibilities in the Plan.

Despite the drastic rewriting of the Plan that the Elfstrom rule would impose, the Ninth Circuit held that this common law rule does not "relate to" ERISA plans and is, accordingly, not preempted. Relying on New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645 (1995), the court held that the Elfstrom rule does not "mandat[e] employee benefit structures or their administration" and did not "provid[e] alternative enforcement mechanisms." Ward, 135 F.3d at 1287. Ignoring the fact that the application of the Elfstrom rule would result in the payment of benefits that the written terms of the Plan precluded, the Ninth Circuit reasoned it was not preempted because:

> Elfstrom does not dictate the benefits to be provided or the manner in which the plan will be administered. Elfstrom does not require an employer to participate in the administration of a group insurance policy or an insurer to delegate its functions to an employer. Nor does Elfstrom create an "alternative enforcement mechanism" for ERISA plan obligations beyond those set forth in the statute.

Id. at 1287 (footnote omitted). There is no substance to this reasoning.

"A law 'relates to' an employee benefit plan, in the normal sense of the phrase, if it has a connection with or reference to such a plan." Shaw, 463 U.S. at 96-97. While some state laws "may affect employee benefit plans in too tenuous, remote, or peripheral a manner to warrant a finding

that the law 'relates to' the plan," id. at 100 n. 21, the Elfstrom rule is not such a law. By deeming the employer to be the unwilling agent of the insurer, the Elfstrom rule clearly dictates the manner in which the plan will be administered because it substitutes oral or written notice to the employer for the written notice of claim to the insurer that is required by the express terms of the Plan. The rule also creates an "alternative enforcement mechanism" because it allows a participant to receive benefits without complying with the Plan as written and would require the payment of benefits when the express terms of the Plan preclude such payment. Put simply, the Elfstrom rule "relates to" the Plan because it changes the Plan.

Moreover, the Elfstrom rule conflicts with the terms of ERISA. ERISA requires a written plan which designates the named fiduciaries and permits the named fiduciaries to delineate their respective duties and responsibilities. 29 U.S.C. § 1102(a)(1); id., § 1105(c)(1). Unless the plan provides procedures for delegating a fiduciary's duty to another fiduciary or person, those duties may not be delegated. Id., §1105(c)(2). The Elfstrom rule flouts these provisions. Through its imputation of an agency relationship, the rule creates a fiduciary[6] and assigns that fiduciary duties and responsibilities that he did not agree to undertake or perform.

In addition, the Ninth Circuit's rationale for the imposition of the Elfstrom rule ignores reality. While the Ninth Circuit characterizes the employer's provision of employee information, which is necessary to effectuate the insurance, as

---

6. "Agency is the fiduciary relation which results from the manifestation of consent by one party to another that the other shall act on his behalf and subject to his control, and consent by the other so to act." Restatement (Second) of Agency § 1.

the "function" of the insurer, that information is peculiarly in the hands of the employer, not the insurer. It is the employer, not the insurer, who knows that a new employee has begun employment and the terms of that employment.[7] To avoid the unintended creation of an agency relationship under the Elsftrom rule, insurers would be required to uncover or develop this information without relying on the employer, adding significant costs to the administration of ERISA plans to the detriment of employers and their employees.

ERISA sought to encourage employers to offer and insure employee benefit plans. Multi-state employers will be unable to offer a single national plan if varying common law rules of the fifty states can be used to circumvent the express terms of benefit plans. Congress did not intend this result when it enacted ERISA and its "crowning achievement," the preemption provision. Shaw, 463 U.S. at 99 *quoting* 120 Cong. Rec. 29197 (1974) (remarks of Representative Dent).

CONCLUSION

For the reasons stated above, this Court should reverse the Ninth Circuit and remand with instructions to affirm the summary judgment in favor of UNUM and the Plan.

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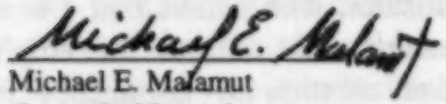
7. Even assuming that the employer were the agent of the insurer for the tasks the Ninth Circuit identified, the employer would not automatically become the agent of the insurer for the purpose of receiving a participant's notice of claim. Restatement (Second) of Agency § 1, illus. 3.

Respectfully submitted,



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IN THE

Supreme Court of the United States

OCTOBER TERM, 1998

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

BRIEF *AMICI CURIAE* OF THE AMERICAN COUNCIL OF LIFE INSURANCE, THE HEALTH INSURANCE ASSOCIATION OF AMERICA AND STANDARD INSURANCE COMPANY IN SUPPORT OF PETITIONER

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IN THE

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---

BRIEF AMICI CURIAE OF THE AMERICAN COUNCIL OF LIFE INSURANCE, THE HEALTH INSURANCE ASSOCIATION OF AMERICA AND STANDARD INSURANCE COMPANY IN SUPPORT OF PETITIONER

INTEREST OF *AMICI CURIAE*[1]

The American Council of Life Insurance represents more than 500 member life insurance companies that together underwrite the vast majority of disability and life insurance in the United States. The Health Insurance Association of America is an advocate for the private market-based health insurance system, representing more than 200 members which provide medical expense and supplemental insurance, as well as long-term care insurance and disability income protection, to more than 110 million Americans. These *amici's* members include major providers of disability, health, life and other group insurance to employee benefit plans subject to the Employee Retirement Income Security Act of 1974 ("ERISA"). Standard Insurance Company is one of the nation's largest providers of group long-term disability and retirement insurance, with over 60,000 group clients representing more than 4 million individual participants in many different states.

This case presents questions of vital interest to *amici* and their members regarding the scope of ERISA's preemption of state law. The decision below applies state common law rules to claims for benefits under ERISA-covered employee benefit plans. Many of the plans served by *amici*'s members operate on a multistate or even nationwide basis. Unless the

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[1] Pursuant to Rule 37.6, *amici curiae* state that this brief was not authored, in whole or in part, by counsel to a party and that no monetary contribution to the preparation or submission of this brief was made by any person or entity other than the *amici curiae* or their counsel. This brief is filed with the consent of the parties. Their letters of consent have been filed with the Clerk of the Court.

decision below is reversed, the cost and complexity of claims administration in these plans will increase, and the Congressional intent to create through ERISA uniform federal regulation of employee benefit plans will be thwarted.

SUMMARY OF ARGUMENT

Section 514 of ERISA, 29 U.S.C. § 1144, preempts all state laws that "relate to" ERISA-covered employee benefit plans but saves from that preemption laws which regulate insurance. The decision of the court of appeals in this case permits a participant in an ERISA-covered employee benefit plan to avoid the plan's claim filing deadline through application of two California common law rules. First, it holds that California's notice-prejudice rule, under which late claim filing is excused unless the insurer providing benefits is prejudiced by the late filing, is saved from preemption as a law which regulates insurance. Second, it holds that California's *Elfstrom* rule of agency, under which the employer sponsoring the ERISA plan is treated as the agent of the insurer for purposes of receiving notice of claims for plan benefits, does not relate to the plan.

In applying these California rules to a benefit claim under an ERISA plan, the court of appeals wrongly chopped ERISA preemption from both ends. State law rules that are directly applied to claims for ERISA-covered benefits necessarily relate to the ERISA plan that provides those benefits. Contrary to the court of appeals' rationale, Congress did not intend that ERISA and state law jointly regulate employee benefit plans. Rather, ERISA's preemption provision was designed to preserve uniform federal

regulation, to the exclusion of state law. Moreover, application of a state law rule that treats the employer as the agent of an insurer because of the employer's fiduciary and other duties under ERISA clearly intrudes on a regulatory field occupied by ERISA.

The court of appeals also erred in holding that the notice-prejudice rule was saved from preemption as a law which regulates insurance. This Court has previously established that whether a state law regulates insurance depends on a common-sense view of insurance regulation and factors developed to identify the business of insurance under the McCarran-Ferguson Act. The California common law rules at issue here are analytically indistinguishable from the Mississippi common law causes of action that this Court held were not saved as laws regulating insurance in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987). Because these rules derive from general common law principles, they fail a common-sense view of insurance regulation and the third McCarran-Ferguson factor. Since they do not spread insurance risk, as the court of appeals conceded as to the notice-prejudice rule, and do not affect integral terms of the policy, they also fail the other McCarran-Ferguson factors. Accordingly, they are not saved from preemption, and the court of appeals erred in holding to the contrary.

ARGUMENT

I. THE APPLICATION OF STATE LAW RULES TO A CLAIM FOR BENEFITS UNDER AN ERISA PLAN "RELATES TO" THAT PLAN FOR PREEMPTION PURPOSES

The court of appeals in this case applied two state law rules to determine whether a benefit claim was timely filed under an ERISA-covered employee benefit plan. First, following its earlier decision in *Cisneros v. UNUM Life Insurance Co. of America*, 134 F.3d 939 (9th Cir. 1998), the court held that the filing of a claim after the expiration of the plan's filing deadline could be excused under California's "notice-prejudice" rule if the insurer providing the benefits was not prejudiced by the late filing. (App. 5a-6a.) Second, the court applied California's *Elfstrom* rule, under which the employer sponsoring the plan is treated as the agent of the insurer so that timely notice of the claim to the employer excuses the late filing with the insurer. (App. 9a-11a.) Since application of state law rules to a claim for benefits under an ERISA plan is precluded by ERISA's express preemption provision, § 514, 29 U.S.C. § 1144, the court of appeals erred, and its judgment should be reversed.

The threshold preemption inquiry is whether a state law "relates to" an ERISA plan within the meaning of § 514(a).[2]

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[2] Except as provided in subsection (b) of this section, the provisions of this subchapter and subchapter III of this chapter shall supersede any and all State laws insofar as they may now or hereafter relate to any employee benefit plan described in section 4(a) and not exempt under section 4(b).

The court of appeals did not address whether application of the notice-prejudice rule related to an ERISA plan. It did, however, conclude that application of the *Elfstrom* rule to the plan did not "relate to" the plan. (App. 21a-22a.) Under this Court's prior decisions, however, both rules relate to the plan since they directly affect a claim for plan benefits.

In its pre-ERISA decision in *Elfstrom v. New York Life Insurance Co.*, 432 P.2d 731 (Cal. 1967), the California Supreme Court held that an employer that participates in the administration of a group insurance policy which provides benefits to employees becomes an agent of the insurer. In applying the *Elfstrom* rule of agency to this case, the court of appeals quoted extensively and with approval from *Turrill v. Life Insurance Co. of North America*, 753 F.2d 1322 (5th Cir. 1985). (App. 16a-18a.) *Turrill* followed *Elfstrom* to hold that a late claim under a disability insurance policy (which, as in this case, provided benefits under an ERISA-covered employee benefit plan) was not untimely if the employer that sponsored the plan received timely notice. *Id.* at 1324. In holding that the employer could be the agent of the insurer for purposes of notice of claims, the *Turrill* court relied heavily on ERISA's imposition of fiduciary duties on the employer with regard to the employee benefit plan, concluding that "proof of an employer's ERISA-based reporting and fiduciary responsibilities with respect to a group insurance policy in itself raises an issue" regarding "the existence of an agency relationship between the employer and group insurer." *Id.* at 1325.

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29 U.S.C. § 1144(a).

After discussing *Turrill*, the court of appeals applied its rationale to the facts of this case:

> Arguably, MAC [respondent's employer] has assumed fiduciary duties under ERISA in the administration of the MAC Plan. Consistent with *Turrill*, proof of MAC's fiduciary duties under ERISA with respect to UNUM's group insurance policy raises an issue under California law as to the existence of an agency relationship between the employer and the group insurer in light of *Elfstrom*.

(App. 19a-20a (footnote omitted).) As the court observed, "Nothing in *Turrill* even hints that state agency law is somehow preempted by ERISA." (App. 18a.) Indeed, the question of ERISA preemption was apparently entirely overlooked in *Turrill* and is not mentioned in the decision.

The court of appeals in this case, however, squarely addressed the preemption issue. The court began its consideration of § 514(a)'s "relates to" clause with citation to several of this Court's many decisions interpreting that clause, principally *New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Insurance Co.*, 514 U.S. 645 (1995) ("*Travelers*"). (App. 20a-21a.) The court then addressed the interaction of preemption and the *Elfstrom* rule and stated:

> ERISA and *Elfstrom* are not anathema. *Elfstrom* does not dictate the benefits to be provided or the manner in which the plan will be administered . . .
>
> As *Turrill* illustrates, the principle that an employer who undertakes responsibilities in

> administering an employee benefit plan assumes fiduciary duties under ERISA meshes smoothly with the *Elfstrom* rule that an employer who assumes such responsibilities in administering a group insurance policy acts as the agent of the insurer.

(App. 21a-22a, citing *Turrill*, 753 F.2d at 1324-25.) Thus, the court concluded:

> In the context of a claim for unpaid benefits under [ERISA] § 502(a), ERISA does not operate to preempt the application of the state law embodied in *Elfstrom* and its progeny to determine the question of timeliness of notice and proof of claim.

(App. 24a.)

The holding of the court of appeals that ERISA does not preempt the *Elfstrom* rule is wrong in several respects. First, the court's conclusion that the *Elfstrom* rule "does not dictate . . . the manner in which the plan will be administered" (App. 21a) is simply mistaken. The plan document at issue in this case provides that a claim is timely only if received by the insurer within a specified deadline. (App. 4a-5a.) The *Elfstrom* rule directly alters this plan term by permitting notice to the employer to substitute for notice to the insurer.

Moreover, the court's observation that the *Elfstrom* rule "meshes smoothly" with ERISA (App. 22a) entirely misses the purpose of ERISA preemption: to establish exclusive federal regulation of employee benefit plans. In *Travelers*, the Court noted that a question of preemption "turn[s] on Congress's intent." 514 U.S. at 655. Unable to glean

congressional intent from "the unhelpful text" of the "relates to" clause, the Court recognized that Congress's intent in enacting § 514(a) was "to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern,'" *id.* at 656, quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981), and "to avoid a multiplicity of regulation in order to permit the nationally uniform administration of employee benefit plans." *Id.* at 657.

Despite its quotation of this latter passage from *Travelers* (App. 21a), the court of appeals concluded that ERISA and state law could jointly apply to govern claims under employee benefit plans. Exclusive and nationally uniform federal regulation of plans, however, cannot co-exist or "mesh" with state regulation. Rather, to be exclusive, federal regulation must exclude state law.

This Court has repeatedly held that ERISA's preemption is not limited to state laws that conflict with ERISA but extends to the entire field of employee benefit plan regulation. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 739 (1985). Thus, in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), the Court considered whether Mississippi common law causes of action could be applied to provide remedies for a claim involving alleged bad faith processing of benefits under an ERISA plan. Noting that there was "no dispute" that those causes of action related to an ERISA plan, the Court nonetheless reemphasized "that the pre-emption clause is not limited to 'state laws specifically designed to affect employee benefit plans.'" *Id.* at 47-48, quoting *Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983). Since the common law causes of action asserted in *Pilot Life* involved "processing of a claim for benefits under

an employee benefit plan," they "undoubtedly meet the criteria for pre-emption under § 514(a)." *Id.* at 48.

The Court's rationale in favor of preemption in *Pilot Life* also requires preemption of the *Elfstrom* rule as applied to a claim for benefits under an ERISA plan.[3] Indeed, the *Elfstrom* rule is even more closely related to an ERISA plan than were the general common law claims held preempted in *Pilot Life*. The *Elfstrom* rule as applied in this case rests its conclusion of agency on the duties imposed by ERISA on an employer that sponsors an employee benefit plan. In *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133 (1990), the Court held that ERISA preempted a state law claim asserting that an employee had been wrongfully discharged in order to interfere with his rights under an ERISA-covered pension plan. Since "the existence of a pension plan is a critical factor" in the application of the state law, the Court had "no difficulty in concluding" that the state law "relates to" an ERISA plan. *Id.* at 139-40. Likewise, here, the employer's duties under ERISA cannot provide the rationale for application of state law. To the contrary, because the *Elfstrom* rule depends on proof of these ERISA duties, for that reason alone, it relates to the plan within the meaning of § 514(a).

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[3] Likewise, the notice-prejudice rule "relates to" a plan when applied to a claim for ERISA plan benefits. As noted above, the *Cisneros* court did not address whether this rule related to the plan, although it quoted from *Travelers* for the proposition that "[t]he Supreme Court recently has narrowed the scope of ERISA's 'related to' language." *Cisneros*, 134 F.3d at 944 n.3. In *O'Connor v. UNUM Life Insurance Co. of America*, 146 F.3d 959 (D.C. Cir. 1998), which followed *Cisneros* in holding California's notice-prejudice rule not preempted, the parties agreed that the rule related to the ERISA plan. *Id.* at 962.

II. THE CALIFORNIA COMMON LAW RULES ARE NOT SAVED FROM PREEMPTION AS LAWS WHICH REGULATE INSURANCE

Even if a state law relates to an ERISA plan within the meaning of § 514(a), it may still be saved from preemption under § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), if it is a law "which regulates insurance."[4] Because of its holding that the *Elfstrom* rule did not fall within § 514(a), the court of appeals had no occasion to consider whether that rule fell within this "saving" clause. It expressly followed *Cisneros*, however, to hold that California's notice-prejudice rule was saved from preemption. (App. 5a.)

In reaching this conclusion, the *Cisneros* court referred to *Metropolitan Life*, in which this Court first addressed ERISA's saving clause. 134 F.3d at 944-45. There, the Court held that whether a state law "regulates insurance" should be determined by whether the law fits a "common-sense view" of insurance regulation and by reference to three criteria identified for determining the "business of insurance" under the McCarran-Ferguson Act, 15 U.S.C. §§ 1011-15. *Metropolitan Life*, 471 U.S. at 740-43, quoting *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982).

The *Cisneros* court first concluded that the notice-prejudice rule fit a "common-sense view" of insurance

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[4] Except as provided in subparagraph (B), nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking, or securities.

29 U.S.C. § 1144(b)(2)(A).

regulation because it "dictates the terms of the relationship between the insurer and insured" and "is directed specifically at the insurance industry and is applicable only to insurance contracts." 134 F.3d at 945. Although the court correctly cited to *Pilot Life* for the meaning of this "common-sense" test, *Pilot Life* actually supports the contrary view.

In *Pilot Life*, the Court applied *Metropolitan Life* to hold that the Mississippi law of bad faith was *not* a state law that "regulates insurance." The Court recognized that "the Mississippi Supreme Court has identified its law of bad faith with the insurance industry." 481 U.S. at 50. It held, however, that bad faith law did not fit a common sense view of insurance regulation because it was not "specifically directed toward" the insurance industry but had its "roots . . . firmly planted in the general principles of Mississippi tort and contract law." *Id.*

Other than its general quotation from *Pilot Life*, the *Cisneros* court made no attempt to apply *Pilot Life*'s analysis of Mississippi bad faith law to California's notice-prejudice rule. The doctrine underlying this rule—that prejudice must result before a failure to give required notice (or to perform a contractual condition) will work a forfeiture—has its roots in the general principles of California contract law[5] and has been applied across the legal spectrum.[6] California courts

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[5] *See* Restatement (Second) of Contracts § 229 (1979) (stating general principle against disproportionate forfeiture).

[6] *See, e.g., Industrial Asphalt v. Garrett Corp.*, 226 Cal. Rptr. 17 (Cal. Ct. App. 1986) (failure to serve statutory notice of mechanic's lien claim effective to defeat lien where no prejudice resulted); *Conservatorship of Rand*, 57 Cal. Rptr. 2d 119 (Cal. Ct. App. 1996) (failure to give notice of citation to proposed conservatee harmless where no prejudice resulted).

have incorporated the legal maxim that "law abhors a forfeiture" into the State's common law, *Ballard v. MacCallum*, 101 P.2d 692 (Cal. 1940), and the doctrine underlying the notice-prejudice rule, as well as the notice-prejudice rule itself, have sprung from this tenet.[7] Thus, the notice-prejudice rule is not "directed specifically at the insurance industry" as the Ninth Circuit found, *Cisneros*, 134 F.3d at 945, but is merely a specific application of the general principle that disproportionate forfeiture should be avoided in the enforcement of contracts.

The *Cisneros* court also determined that its conclusion that the notice-prejudice rule regulates insurance "holds up when measured against the McCarran-Ferguson factors." *Id.* These factors were described in *Union Labor Life Insurance Co. v. Pireno*, as

> *First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*,

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[7] *See O'Morrow v. Borad*, 167 P.2d 483, 487 (Cal. 1946) (court may excuse compliance with condition in contract to avoid forfeiture). *See also Aetna Cas. & Surety Co. v. Murphy*, 538 A.2d 219, 221 (Conn. 1988) (quoting Restatement (Second) of Contracts § 229 to justify Connecticut notice-prejudice rule); *Woodmen's Accident Ass'n v. Byers*, 87 N.W. 546, 548 (Neb. 1901) (same as to Nebraska notice-prejudice rule).

> whether the practice is limited to entities within the insurance industry.

458 U.S. at 129 (emphasis in original). The *Cisneros* court conceded that the notice-prejudice rule did *not* satisfy the first McCarran-Ferguson factor, since it "may not have the effect of transferring or spreading the policyholder's risk." 134 F.3d at 945. The court held, however, that "the other two McCarran-Ferguson factors weigh heavily in favor of the conclusion that the notice-prejudice rule 'regulates insurance.'" *Id.* at 946.

The *Cisneros* court's conclusion that the notice-prejudice rule did not meet the first McCarran-Ferguson factor was unquestionably correct since that rule does not transfer or spread policyholder risk. As the court noted, the rule does, in a general sense, affect the risk that the insured will prevail against the insurer, since it permits the insured to prevail even where a claim filing deadline is not met. *Id.* The first McCarran-Ferguson factor, however, refers to an entirely different type of risk, *i.e.*, the fundamental risk that is transferred from insured to insurer by the insurance contract. *See Pireno*, 458 U.S. at 130-31 (the risk-spreading principle concerns the risk of injury that the insurer has contractually agreed to bear for the insured). Thus, although the rule affects the risks of paying claims filed after the policy deadline, it does not spread the risk of disability insurance coverage for which the parties contracted.

Rules or laws that merely affect the administration of an insurance policy, rather than its terms, fail to satisfy the first McCarran-Ferguson factor because they do not affect the

transfer of insurance risk.[8] Accordingly, the Mississippi bad faith law at issue in *Pilot Life*—which, like the notice-prejudice rule, was a common law rule that assisted the insured in a claim against the insurer but did not serve to spread risk—was held not to satisfy the first factor. 481 U.S. at 51. In contrast, in *Metropolitan Life* the Court held that the state law at issue, which mandated inclusion of certain benefits in a group insurance policy, satisfied the first factor because it caused the cost of mental health care to be shared by all policyholders in the state, thus affecting the spread of risk. 471 U.S. at 743.

While the *Cisneros* court correctly concluded that the notice-prejudice rule did not meet the first McCarran-Ferguson factor, it erred in holding both that the rule satisfied the two other factors and that the rule regulated

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[8] *See Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993) (statute preventing rescission of policy following discovery that incorrect application information was submitted, absent fraud, did not shift policyholder risk, although it spread the legal risks of innocent misrepresentations onto the insurer); *DeBruyne v. Equitable Life Assurance Soc'y of Am.*, 920 F.2d 457, 469 (7th Cir. 1990) (ERISA preempts a New York insurance law prohibiting the misrepresentation of an insurance contract's terms because, among other things, the law does not spread policyholder risk but rather "forces the insurer to bear the legal risks associated with [fraudulent] policy language"); *McMahan v. New England Mutual Life Ins. Co.*, 888 F.2d 426, 429 (6th Cir. 1988) (saving clause does not apply to Kentucky case law requiring courts to interpret ambiguous terms in an insurance contract in favor of the insured because the law did "not effect a spreading or transferring of policyholders' insurance risk, but rather forces the insurer to bear the legal risks associated with ambiguous policy language").

insurance despite its failure to affect the transfer of risk. The core of its error was its conclusion that the notice-prejudice rule, like the mandated benefits law at issue in *Metropolitan Life*, satisfied the second McCarran factor because it "effectively creates a mandatory contract term" and thus affects "an integral part of the policy relationship" between insurer and insured. 134 F.3d at 946-47. Unlike a mandated benefits law, however, the notice-prejudice rule does not alter in any substantive way the terms of insurance coverage. Rather, like the bad faith law at issue in *Pilot Life*, it merely affects the procedures for handling claims under the insurance contract and thus "does not define the terms of the relationship between" those parties. *Pilot Life*, 481 U.S. at 51.

Even if the notice-prejudice rule is interpreted as creating a "mandatory contract term" in the insurance policy,[9] that term—as demonstrated by the rule's failure to satisfy the first McCarran-Ferguson factor—does not serve to spread policyholder's risk, and thus cannot be considered to be a substantive part of the policy relationship between insured and insurer. In *Metropolitan Life*, the Court suggested that "substantive terms" of group-health insurance contracts were those terms that affected specific *coverage* to which the

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[9] The court of appeals was incorrect in finding that the notice-prejudice rule "creates a mandatory contract term." The rule does not mandate anything; an insurer is not required to place a deadline in its policies by which claims must be filed. If it does so, it can specify any deadline it chooses. The notice-prejudice rule simply provides that, whatever the substantive terms of the contract for disability insurance may be, time limitations on claim submissions are valid only under certain conditions.

insured was entitled, for example, continuing coverage for disabled dependents or mandatory coverage of infants at birth. 471 U.S. at 729. In contrast, the practices or laws examined by the Court in *Pilot Life, Group Life & Health Insurance Co. v. Royal Drug Co.*, 440 U.S. 205 (1979), *Pireno*, and *Securities and Exchange Commission v. National Securities, Inc.*, 393 U.S. 453 (1969), did not affect coverage terms and thus were held not to satisfy the second McCarran-Ferguson factor (or its pre-*Pireno* equivalent).[10] Several appellate decisions under ERISA have held that a law affecting a purely administrative contract term cannot be considered an integral part of the policy relationship between the insurer and insured.[11]

If the Ninth Circuit's analysis in *Cisneros* were followed, then virtually any procedural rule affecting an insured employee benefit plan could be saved from preemption as a law which regulates insurance, even though it has no effect

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[10] *See Pilot Life*, 481 U.S. at 51, *Royal Drug*, 440 U.S. at 215-16; *Pireno*, 458 U.S. at 119; *National Securities*, 393 U.S. at 460.

[11] *See Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 942 (6th Cir. 1997) (Ohio statute which does not affect policyholder risk cannot affect substantive terms of the policy and, thus, fails second McCarran-Ferguson factor); *Kelley v. Sears, Roebuck and Co.*, 882 F.2d 453, 456 (10th Cir. 1989) (Colorado statute which prohibited unfair or deceptive practices in the industry "did not control the substantive terms" of the policy); *Smith v. Jefferson Pilot Life Ins. Co.*, 14 F.3d 562, 570 (11th Cir. 1994) (Georgia statute which required written notice of cancellation of insurance coverage did not affect the substantive terms of the policy or an integral part of the relationship between the insurer and insured).

on the spreading of risk. This result would be contrary to decisions of this Court which state that an "indispensable characteristic of insurance" is the "spreading and underwriting of policyholder's risk." *Royal Drug*, 440 U.S. at 211-12 (following an analysis of the legislative history of the McCarran-Ferguson Act). Because the notice-prejudice rule does not regulate or implicate the "true underwriting of risks, the one earmark of insurance," *Securities and Exch. Comm'n v. Variable Annuity Life Ins. Co. of Am.*, 359 U.S. 65, 73 (1959), it cannot affect the policy relationship of the insured and insurer and thus cannot be a regulation of insurance.

The *Cisneros* court's conclusion that the notice-prejudice rule satisfied the third McCarran-Ferguson factor, that it be limited to entities in the insurance industry, 134 F.3d at 946, merely repeats the error of its earlier conclusion that the rule is directed at the insurance industry. As the Court said in rejecting a similar argument in *Pilot Life*, even if a common law doctrine is "associated with the insurance industry," its common law roots preclude a finding that it is limited to entities in the insurance industry. 481 U.S. at 51.

The *Cisneros* court concluded its discussion of the saving clause with the question "If California's rule does not regulate insurance, what does it regulate?" 134 F.3d at 946. Like many rhetorical questions, this one has a straightforward answer that the rhetoric obscures. What the notice-prejudice and *Elfstrom* rules regulate are the administration of the policy. When that policy provides benefits under an ERISA plan, the rules function as a "regulation of an ERISA plan" that is preempted by ERISA. *Travelers*, 514 U.S. at 659. While the *Cisneros* court found "unconvincing" the

notion that Congress could have intended to save from preemption state regulation of the terms of an insurance contract, while preempting procedural rules affecting administration of that contract, 134 F.3d at 946-47, that is exactly what ERISA provides. As the Court held in *Metropolitan Life*, the states remain free to regulate the substantive terms of insurance contracts. 471 U.S. at 736. As *Pilot Life* holds, however, common law rules that merely affect the procedures for handling claims for benefits are not laws which regulate insurance and are not saved from preemption. 481 U.S. at 50-51.[12]

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[12] Although the court of appeals did not reach the issue of whether the *Elfstrom* rule is saved from preemption, the analysis above demonstrates that it clearly is not a regulation of insurance under the *Metropolitan Life* test and thus is not saved from ERISA's preemptive reach. As the California Supreme Court noted, the *Elfstrom* rule is an application of common law agency rules that are incorporated into California law in other contexts. 432 P.2d at 738. Like the notice-prejudice rule, therefore, the *Elfstrom* rule is merely a specific application of a general principle of law—specifically, that one acting on behalf of another and for the benefit of another is the other's agent. Also like the notice-prejudice rule, the *Elfstrom* rule does not spread or even address the risk transferred between insured and insurer. Rather, it merely affects administrative procedures for handling claims. Thus, the *Elfstrom* rule fails the common-sense test as well as each of the McCarran-Ferguson factors and, accordingly, is not a regulation of insurance.

CONCLUSION

For the foregoing reasons, *amici* respectfully urge that the Court reverse the decision of the Court of Appeals.

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In the Supreme Court of the United States

OCTOBER TERM, 1998

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF THE BUSINESS ROUNDTABLE AS *AMICUS CURIAE* IN SUPPORT OF PETITIONER

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QUESTIONS PRESENTED

Amicus will address the following questions:

1. Whether a state common-law rule that imposes obligations on employee welfare plans is preempted by the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*

2. Whether a state common-law rule that imposes obligations on plans that are inconsistent with those stated in the plan documents is preempted by ERISA.

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INTEREST OF THE *AMICUS CURIAE*

The Business Roundtable is an association of chief executive officers of leading U.S. corporations with a combined workforce of more than 10 million employees in the United States; these corporations sponsor plans that provide health insurance for some 25 million people.[1] The chief executives are committed to advocating public policies that foster vigorous economic growth; a dynamic global economy; and a well-trained and productive U.S. workforce essential for future competitiveness. Established in 1972, the Roundtable was founded in the belief that chief executives of major corporations should take an increased role in the continuing debates about public policy.

The proper interpretation of ERISA preemption principles is a matter of profound importance both to the companies represented in the Roundtable and to those companies' employees. This Court has noted "the centrality of pension and welfare plans in the national economy, and their implications for the financial security of the Nation's work force." *Boggs* v. *Boggs*, 117 S. Ct. at 1754, 1760 (1997). Yet the rule adopted by the court of appeals in this case will lead to the imposition of inconsistent obligations on ERISA plans, interfere with sound plan administration, and ultimately redound to the disadvantage of plan beneficiaries by forcing reductions in plan benefits — or by inducing employers to refrain from offering plans altogether. Because these consequences would injure companies and employees

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[1] Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief *amicus curiae*. Their letters of consent have been filed with the Clerk of the Court.

Pursuant to Rule 37.6 of the Rules of this Court, *amicus* states that this brief was not authored in whole or in part by counsel for a party, and no person or entity, other than *amicus* or its members, made a monetary contribution to the preparation or submission of this brief.

throughout the Nation, *amicus* submits this brief to assist the Court in the resolution of this case.

STATEMENT

1. The Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1001 *et seq.*, is a comprehensive statute that regulates both pension plans and welfare plans that "provid[e] employees with fringe benefits." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983). This case concerns the provisions of ERISA that address the statute's preemptive effect on state law. Section 514(a), the "preemption clause," preempts "any or all State laws insofar as they may now or hereafter relate to any employee benefit plan" covered by ERISA. 29 U.S.C. § 1144(a). State laws that relate to ERISA plans may be saved from preemption by the statute's "saving clause," however, if they "regulate[] insurance, banking, or securities." Section 514(b)(2)(A), as set forth in 29 U.S.C. § 1144(b)(2)(A).

2. In this case, petitioner UNUM Life Insurance Company of America ("UNUM") issued a group long-term disability policy to fund an employee welfare benefit plan sponsored by Management Analysis Company ("MAC"). MAC served as the administrator of the plan, but UNUM was responsible for claims handling and payment functions, as well as for the fiduciary review required by § 503 of ERISA. Respondent John Ward, who served as MAC's President and Chief Executive Officer, was a participant in the plan. Ward asserts that he became disabled in May 1992, but he did not submit a claim under the disability policy until April 1994, nearly two years after the onset of the claimed disability. Pet. App. 2a-3a. UNUM denied Ward benefits because his submission was untimely under the policy, which requires a beneficiary to submit a written notice of claim within 30 days of the onset of disability, and to submit a written proof of claim no later than one year and 180 days after the onset of disability. *Id.* at 4a-5a, 42a-43.

Ward then brought this suit against the plan and UNUM, seeking payment of plan benefits. The district court rejected the claim (Pet. App. 27a-33a), but the court of appeals reversed. *Id.* at 1a-25a. The court agreed that "Ward's submission of notice and proof of his claim plainly was untimely under the express terms of the UNUM policy." *Id.* at 5a. But the court nevertheless held that two California common law rules allowed Ward's claim to survive: the "notice-prejudice rule," which the court characterized as "prevent[ing] an insurance company from avoiding liability on the basis of untimely notice or submission of proof unless the company proves it has been substantially prejudiced by the delay" (*Cisneros* v. *UNUM Life Insurance Company of America*, 134 F.3d 939, 943 (9th Cir. 1998), petition for cert. filed, 66 U.S.L.W. 3773 (U.S. May 20, 1998), No. 98-1867); and the so-called "*Elfstrom* rule," which holds that an employer that performs administrative tasks under an insured welfare plan is the agent of the insurer. Pet. App. 8a-12a.

The court of appeals rejected UNUM's argument that these state common law rules were preempted by ERISA. Relying on its decision in *Cisneros*, the court first held that the notice-prejudice rule is saved from preemption by ERISA's saving clause. Pet. App. 5a-6a. The court went on to hold that the *Elfstrom* rule is not preempted by the preemption clause because "*Elfstrom* does not dictate the benefits to be paid or the manner in which the plan will be administered. * * * Nor does *Elfstrom* create an 'alternate enforcement mechanism' for ERISA plan obligations beyond those set forth in the statute." *Id.* at 21a-22a. The court remanded the case for factual findings related to the application of these two state law rules. *Id.* at 25a.

INTRODUCTION AND SUMMARY OF ARGUMENT

A. The proper interpretation of ERISA's preemption provisions is a matter of enormous importance to companies

and employees across the Nation. As Congress explained when it enacted ERISA almost 25 years ago,

> the growth in the size, scope, and numbers of employee benefit plans in recent years has been rapid and substantial; * * * the continued well-being and security of millions of employees and their dependents are directly affected by these plans; * * * they are affected with a national public interest[;] [and] they have become an important factor affecting the stability of employment and the successful development of industrial relations * * *.

29 U.S.C. § 1001(a). Benefit plans have only grown in importance in the intervening years, as the number of beneficiaries has continued to increase.

Congress recognized the centrality of benefit plans to the national economy by providing, with the enactment of ERISA, that the regulation of such plans is "exclusively a federal concern." *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981). Congress therefore itself established the rules governing plan administration, using ERISA to "set[] various uniform standards, including rules concerning reporting, disclosure, and fiduciary responsibility, for both pension and welfare plans." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 91 (1983). The result was "an intricate, comprehensive statute." *Boggs* v. *Boggs*, 117 S. Ct. 1754, 1760 (1997).

Congress also recognized that the preemption of state laws that relate to ERISA plans is a crucial element of this regime and is essential to protect the interests of plans, of beneficiaries, and of employers. Members of Congress explained during the debate on ERISA — and this Court repeatedly has agreed — that subjecting plans to the vagaries of state law would have a variety of destructive effects. Requiring plans to comply with inconsistent state rules would cause significant inefficiencies, forcing plan sponsors to vary their administrative mechanisms from State to State. Vague

or changing state laws would lead to unanticipated liability and invite continuing litigation. And conflicting state laws would create considerable uncertainty about the respective obligations of plans and their beneficiaries.

These consequences of state regulation would impose obvious and immediate costs on plans. At the same time, increased state involvement in the regulation of plans inevitably would redound to the disadvantage of plan beneficiaries. Faced with rising costs and liabilities, plan sponsors would have no choice but to reduce benefits or increase the beneficiaries' required contributions. At the extreme, increased burdens and expenses likely would discourage some employers from offering benefit plans at all.

B. These imperatives led Congress to give ERISA a notably expansive preemption provision, and they should shape the resolution of the preemption claims in this case. The *Elfstrom* rule applied by the court of appeals must be preempted because it refers directly to ERISA plans and therefore intrudes on an area of exclusive federal concern. In addition, allowing States to affect plan administration in the manner approved by the court of appeals would invite the very sort of conflicting state regulation that Congress condemned as destructive to sound plan administration. The state notice-prejudice rule approved by the Ninth Circuit also should not stand: it directly conflicts with the substantive provisions of ERISA that give plan documents controlling force, and gives an unduly broad reading to the ERISA saving clause.

ARGUMENT

In its decisions interpreting ERISA's preemption provisions, this Court has been guided both by the statute's "clearly expansive" language and by the manifest congressional purpose "to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern.'" *New York State Conference of Blue Cross & Blue*

Shield Plans v. *Travelers Insurance Co.*, 514 U.S. 645, 655, 656-657 (1995) (quoting *Alessi* v. *Raybestos-Manhattan, Inc.*, 451 U.S. 504, 523 (1981)). The decision below, however, disregarded both of these considerations. The Ninth Circuit's restrictive construction of the preemption clause is grounded on a patent misreading of this Court's decisions. And its expansive application of the insurance saving clause finds no basis either in the statutory purpose or in this Court's holdings. If not set aside, the ruling below accordingly will frustrate congressional policy, disrupting sound plan administration while injuring employees and other beneficiaries of ERISA welfare plans.

A. The Purposes Of ERISA Require An Expansive Application Of The Statute's Preemption Provision

The Court has noted on several occasions (with more than a little understatement) that the ERISA preemption provisions "'are not a model of legislative drafting'" (*FMC Corp.* v. *Holliday*, 498 U.S. 52, 58 (1990) (quoting *Metropolitan Life Ins. Co.* v. *Massachusetts*, 471 U.S. 724, 739 (1985)). When interpreting Section 514's language, it therefore is useful to begin at the beginning, with an examination of the statutory history, structure, and purpose. That background makes clear that Congress acted advisedly in developing an expansive preemption clause: any attempt to be faithful "to the objectives of the ERISA statute" (*Travelers*, 514 U.S. at 656) will leave a distinctly limited and subordinate role for state laws that bear directly on the operation of welfare plans.

1. The ERISA bills that originally passed the House and Senate contained relatively limited preemption clauses that were "applicable only to state laws relating to the specific subjects covered by ERISA." *Shaw* v. *Delta Air Lines, Inc.*, 463 U.S. 85, 98 (1983). See H.R. 2, 93d Cong. 2d Sess.,§ 514(a) (1974), reprinted in 3 Legislative History of the Employee Retirement Income Security Act of 1974 (Comm. Print), pp. 4057-4058 (1976) ("Legislative History")

(bill that passed House preempted laws "relat[ing] to the reporting and disclosure responsibilities, and fiduciary responsibilities, of persons acting on behalf of any employee benefit plan to which part 1 applies"); H.R. 2, 93d Cong., 2d Sess., § 699(a) (1974), reprinted in 3 Legislative History 3820 (bill that passed Senate preempted laws "relat[ing] to the subject matters regulated by this Act or the Welfare and Pension Plans Disclosure Act"). But the Conference Committee rejected those constricted provisions — as well as a narrow alternative proposed directly to the Committee by the administration (see *Shaw*, 463 U.S. at 98-99 n.19) — opting instead for a much more inclusive approach. As the Court has noted repeatedly, this history establishes that Congress acted with deliberation to make "the section's pre-emptive scope * * * as broad as its language." *Id.* at 98. See *Travelers*, 514 U.S. at 661; *FMC Corp.*, 498 U.S. at 58-59; *Ingersoll-Rand Co. v. McClendon*, 498 U.S. 133, 138 (1990); *Pilot Life Ins. Co.* v. *Dedeaux*, 481 U.S. 41, 45-46 (1987).

ERISA's principal sponsors left no doubt that this "deliberately expansive" (*Pilot Life*, 481 U.S. at 45) approach to preemption was essential to protect plans from the litigation and administrative expense that would follow from the necessity of complying with varying state requirements. Senator Javits, for example, explained that

> [b]oth [the original] House and Senate bills provided for preemption of state law, but — with one major exception appearing in the House bill — defined the perimeters of preemption in relation to the areas regulated by the bill. Such a formulation raised the possibility of endless litigation over the validity of State action that might impinge on Federal regulation, as well as opening the door to multiple and potentially conflicting State laws hastily contrived to deal with some particular aspect of private welfare or pension benefit plans not clearly connected to the Federal regulatory scheme.

> Although the desirability of further regulation — at either the State or the Federal level — undoubtedly warrants further attention, on balance, the emergence of a comprehensive and pervasive Federal interest and the interests of uniformity with respect to interstate plans required — but for certain exceptions — the displacement of State action in the field of private employee benefit programs.

120 Cong. Rec. 29942 (1974).

Senator Williams agreed:

> It should be stressed that with the narrow exceptions specified in the bill, the substantive and enforcement provisions of the conference substitute are intended to preempt the field for federal regulations, thus eliminating the threat of conflicting or inconsistent State and local regulation of employee benefit plans. This principle is intended to apply in its broadest sense to all actions of State or local governments, or any instrumentality thereof, which have the force or effect of law.

120 Cong. Rec. 29933 (1974).

Indeed, Representative Dent, in an oft-quoted phrase, characterized as "the crowning achievement of this legislation, the reservation to Federal authority [of] the sole power to regulate the field of employee benefit plans." 120 Cong. Rec. 29197 (1974). He explained that this step was crucial in furthering the interests of plan *beneficiaries*:

> [w]ith the preemption of the field, we round out the protection afforded participants by eliminating the threat of conflicting and inconsistent State and local regulation. * * * The conferees, with the narrow exceptions specifically enumerated, applied this principle in the broadest sense to foreclose any non-Federal regulation of employee benefit plans. Thus, the provisions of section 514 would reach any rule, regulation, practice, or decision

> of any State, subdivision thereof or agency or instrumentality thereof * * * which would affect any employee benefit plan * * *.

Ibid.

2. The Court already has had occasion to examine the manner in which preemption advances the interests of welfare plans and plan beneficiaries. As the Court has recognized, the "most efficient way" for a plan sponsor to meet its responsibilities

> is to establish a uniform administrative scheme, which provides a set of standard procedures to guide processing of claims and disbursement of benefits. Such a system is difficult to achieve, however, if a benefit plan is subject to differing regulatory requirements in differing States. A plan would be required to keep certain records in some States but not in others; to make certain benefits available in some States but not in others; to process claims in a certain way in some States but not in others; and to comply with certain fiduciary standards in some States but not in others.

Fort Halifax Packing Co. v. *Coyne*, 482 U.S. 1, 9 (1987).

Looking to the consequences of subjecting plans to these sorts of unpredictable and varying standards, the Court recognized that "[s]uch a situation would produce considerable inefficiencies, which the employer might choose to offset by lowering benefit levels." *Fort Halifax*, 482 U.S. at 10. The Court therefore found it

> clear that ERISA's pre-emption provision was prompted by recognition that employers establishing and maintaining employee benefit plans are faced with the task of coordinating complex administrative activities. A patchwork scheme of regulation would introduce considerable inefficiencies in benefit program operation, which might lead those employers with existing plans to

> reduce benefits, and those without such plans to refrain from adopting them. Pre-emption ensures that the administrative practices of a benefit plan will be governed only by a single set of regulations.

Id. at 11. For this reason, the Court consistently has sought to "minimize the administrative and financial burden of complying with conflicting directives among States or between States and the Federal Government." *Ingersoll-Rand*, 498 U.S. at 142.

The concern that increasing administrative and litigation costs for plans "could work to the detriment of plan beneficiaries" (*Ingersoll-Rand*, 498 U.S. at 142) by "producing inefficiencies that employers might offset with decreased benefits" (*FMC Corp.*, 498 U.S. at 60) is not fanciful. After all, "[e]mployers or other plan sponsors are generally free under ERISA, for any reason at any time, to adopt, modify, or terminate welfare plans. * * * Nor does ERISA establish any minimum participation, vesting, or funding requirements for welfare plans as it does for pension plans." *Curtiss-Wright Corp.* v. *Schoonejongen*, 514 U.S. 73, 78 (1995). See *Metropolitan Life*, 471 U.S. at 731 ("ERISA * * * contains almost no federal regulation of the terms of benefit plans"). As a result, it is inevitable that increased burdens imposed upon plans by state law will force plan sponsors to impose corresponding increases in premiums and other employee contributions, or to reduce plan benefits to make up the difference. While the application of particular state laws in particular cases might benefit particular plaintiffs, it therefore is plain that any rule diminishing the scope of preemption would, in the long run, "decrease protection for future employees." *Moore* v. *Metropolitan Life Ins. Co.*, 856 F.2d 488, 492 (2d Cir. 1988) (Winter, J.).

Indeed, subjecting plans to varying and changing state laws would have a complex and cascading series of effects — all of them unfortunate. Many employees would be deprived

of insurance protection altogether; in the health setting, for example, even relatively small cost increases drive large numbers of people off of the insurance rolls. See Congressional Budget Office, *Economic Implications of Rising Health Care Costs* (Oct. 1992), at 42-45. Moreover, as healthier employees decided to forgo participation in increasingly expensive health plans, the pool of employees that shares the risk would both decrease and include ever greater percentages of high-risk participants who make demands on the plan, a spiral that would lead to further cost increases and declining participation. Cf. *Metropolitan Life*, 471 U.S. at 731. At the same time, the unpredictability and expense inherent in a regime that is controlled by inconsistent and changing state laws would create "substantial disincentives for even offering [welfare] plans." *Moore*, 856 F.2d at 492. Given "the centrality of pension and welfare plans in the national economy, and their implications for the financial security of the Nation's work force" (*Boggs* v. *Boggs*, 117 S. Ct. 1754, 1760 (1997)), it comes as no surprise that a Congress faced with these dangers opted for a notably broad approach to preemption.

3. Against this background, the one constant in the Court's ERISA holdings is the recognition "that ERISA's pre-emption provision is 'clearly expansive.'" *California Div. of Labor Standards Enforcement* v. *Dillingham Constr., N.A., Inc.*, 117 S. Ct. 832, 837 (1997) (quoting *Travelers*, 514 U.S. at 655). See, *e.g.*, *Barnett Bank* v. *Nelson*, 517 U.S. 25, 38 (1996); *FMC Corp.*, 498 U.S. at 58; *Ingersoll-Rand*, 498 U.S. at 138; *Fort Halifax Packing*, 482 U.S. at 9; *Metropolitan Life*, 471 U.S. at 732; *Shaw*, 463 U.S. at 96, 98. It necessarily follows that "ERISA certainly contemplated the pre-emption of substantial areas of traditional state regulation." *Dillingham*, 117 S. Ct. at 840. With that point in mind, the Court developed what has become a familiar two-part test for ERISA preemption:

> We have repeatedly stated that a law "relate[s] to" a covered employee benefit plan for purposes of § 514(a) "if it has a connection with or reference to such a plan." *Shaw*, [463 U.S.] at 97. * * * This reading is true to the ordinary meaning of "relate to," * * * and thus gives effect to the "deliberately expansive" language chosen by Congress. *Pilot Life*, [481 U.S.] at 46. * * * Under § 514(a), ERISA pre-empts any state law that refers to or has a connection with covered benefit plans (and that does not fall within a § 514(b) exception) "even if the law is not specifically designed to affect such plans, or the effect is only indirect," *Ingersoll-Rand*, [498 U.S.] at 139, and even if the law is "consistent with ERISA's substantive requirements," *Metropolitan Life*, [471 U.S.] at 739.

District of Columbia v. *Greater Washington Bd. of Trade*, 506 U.S. 125, 129-130 (1992) (footnote omitted).

The court of appeals nevertheless declined to apply this test, evidently because it believed that *Travelers* marked a sharp departure from the Court's prior ERISA jurisprudence. See Pet. App. 20a-21a ("the *Travelers* Court concluded that two types of state laws 'relate to' employee benefit plans within § 514(a): laws that 'mandat[e] employee benefit structures or their administration,' and laws that 'provid[e] alternative enforcement mechanisms'"); *Cisneros*, 134 F.3d at 943 n.3 (citing *Travelers* for the proposition that "[t]he Supreme Court recently has narrowed the scope of ERISA's 'related to' language"). But that conclusion is insupportable. *Travelers* simply confirmed a proposition that long had been implicit in this Court's decisions: the term "relate to" cannot be taken "to the furthest reach of its indeterminacy" because "'[r]eally, universally, relations stop nowhere.'" 514 U.S. at 655 (citation omitted). Pointing to that insight, the Court in *Travelers* held that, except in extreme circumstances, a state law will not be preempted if its only connection to an ERISA plan is "an indirect economic effect on the relative costs of

various health insurance packages." *Id.* at 662. See *id.* at 659-660, 664, 668.

In reaching that conclusion, however, the Court in *Travelers* reaffirmed the view that "[t]he governing text of ERISA is clearly expansive" (514 U.S. at 655); it agreed that the preemption clause "indicates Congress's intent to establish the regulation of employee welfare benefit plans 'as exclusively a federal concern'" (*id.* at 656-657 (citation omitted)); it confirmed that "Congress's extension of pre-emption to all 'state laws relating to benefit plans' was meant to sweep more broadly than 'state laws dealing with the subject matters covered by ERISA'" (*id.* at 661 (quoting *Shaw*, 463 U.S. at 98 & n.19)); and it disavowed *none* of the Court's prior decisions in this area. Indeed, more recently, in *Dillingham*, the Court expressly restated the controlling "two-part inquiry: A 'law "relate[s] to" a covered employee benefit plan for purposes of § 514(a) "if it [1] has a connection with or [2] reference to such a plan."'" 117 S. Ct. at 837 (quoting *Greater Washington Bd. of Trade*, 506 U.S. at 129, and *Shaw*, 463 U.S. at 96-97) (bracketed material added by the Court). The Ninth Circuit's failure to apply that test here led it fundamentally astray.

B. The *Elfstrom* Rule "Relates To" ERISA Plans And Therefore Is Preempted

In upholding the *Elfstrom* rule's application to ERISA plans, the court of appeals paid no heed at all to the policies served by the preemption clause. As we have explained, a restrictive approach to preemption harms interests that Congress regarded as crucial to the sound operation of plans. Yet the court of appeals endorsed an approach that would subject plans to inconsistent state rules, that would impose substantial added expenses on plan sponsors, and that — while perhaps benefitting Mr. Ward — would injure plan beneficiaries in the aggregate. A proper application of this Court's precedents, and a faithful adherence to ERISA's

governing principles, require setting the Ninth Circuit's decision aside.

1. At the outset, the *Elfstrom* rule must be preempted because it has a "reference" to ERISA plans. "Where a State's law acts immediately and exclusively on ERISA plans, * * * or where the existence of ERISA plans is essential to the law's operation, * * * that 'reference' will result in pre-emption." *Dillingham*, 117 S. Ct. at 838. That plainly is the case here.

Elfstrom addressed an employer's obligation when it acts as the administrator of a group insurance policy that it obtained for the benefit of its employees. See *Elfstrom* v. *New York Life Ins. Co.*, 67 Cal.2d 503, 509-510 (1967). The California Supreme Court explained that "[t]he administration of a group policy may be handled either by the insurer itself on the basis of information furnished to it by the employer or, as in the present case, by the employer." *Id.* at 509. With that understanding, the court addressed the question "whether an employer acts as the agent of the insurer or of the employees in administering a policy of group insurance." *Id.* at 511. The answer to that question — the *Elfstrom* "rule" announced by the California court and applied by the Ninth Circuit in this case — is that "the employer is the agent of the insurer in performing the duties of administering group insurance policies." *Id.* at 512.

The *Elfstrom* rule therefore is expressly and specifically designed to govern in only one circumstance: when an employer has obtained and is administering a group insurance policy for the benefit of its employees. See also *Metropolitan Life*, 471 U.S. at 727 (describing group insurance). And that means, of course, that the rule is directed expressly and exclusively *at ERISA welfare plans*, which are defined to include, among other things, any "'plan, fund, or program' maintained for the purpose of providing medical or other health benefits for employees or their beneficiaries 'through

the purchase of insurance or otherwise.'" *Greater Washington Bd. of Trade*, 506 U.S. at 127 (quoting ERISA § 3(1), 29 U.S.C. § 1002(1)). See *Travelers*, 514 U.S. at 650-651. The *Elfstrom* rule's "reference" to ERISA plans thus would appear inarguable.

Petitioner's preemption challenge to the *Elfstrom* rule therefore is governed by the repeated decisions of the Court that "'have virtually taken it for granted that state laws which are "specifically designed to affect employee benefit plans" are pre-empted under § 514(a).'" *Ingersoll-Rand*, 498 U.S. at 140 (quoting *Mackey* v. *Lanier Collection Agency & Serv., Inc.*, 486 U.S. 825, 829 (1988)). In *Ingersoll-Rand*, for example, the Court held preempted a state common law action that was brought by an employee who claimed that he had been discharged to prevent the attainment of pension benefits; the Court explained that the state "cause of action makes specific reference to, and indeed is premised on, the existence of a pension plan." *Ibid.* Similarly, in *Greater Washington Board of Trade* the Court struck down a local law that required employers to provide health insurance to injured employees who were eligible for workers' compensation. Explaining that the required coverage was measured by the insurance benefits provided to active employees, the Court held that "any state law imposing requirements by reference to such covered programs must yield to ERISA." 506 U.S. at 130-131. And in *Mackey*, the Court invalidated a state law that specifically *exempted* ERISA plans from an otherwise generally applicable state garnishment provision. 486 U.S. at 828 n.2, 829-830. See also *FMC*, 498 U.S. at 59 (state statute makes a "reference" to ERISA plans and is preempted because it described benefits payable by various health plans).

Rather remarkably, the court of appeals made no mention of *any* of these decisions. Perhaps the court believed that all had been swept away by *Travelers*. If so, it most assuredly was misguided; each of these decisions recently was cited with approval in *Dillingham*. See 117 S. Ct. at 837-838. In

any event, the Ninth Circuit's only effort to explain its holding was the assertion that "*Elfstrom* does not dictate the benefits to be provided or the manner in which the plan will be administered." Pet. App. 21a. Even if the court's characterization of *Elfstrom* were correct, however, its observation would be beside the point, for precisely the same thing could be said of the state laws that were invalidated in *Ingersoll-Rand* and *Mackey*: they also did not dictate benefits or mandate particular methods of plan administration.[2] As in those cases, there is no doubt that the *Elfstrom* rule "act[s] exclusively on, or rel[ies] on the existence of, ERISA plans" (*Boggs*, 117 S. Ct. at 1769 (Breyer, J., dissenting)), and that is enough to require preemption. Under any reading of Section 514(a), *Elfstrom* thus intrudes into "the field of laws regulating 'employee benefit plan[s] described in [29 U.S.C. §] 1003(a).'" *Dillingham*, 117 S. Ct. at 843 (Scalia, J., concurring) (quoting 29 U.S.C. § 1144(a)).

2. The *Elfstrom* rule — and all similar state agency rules — also must be preempted because it has a "connection with" ERISA plans. "[T]o determine whether a state law has the forbidden connection, [the Court] look[s] both to 'the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive,' * * * as well as to the nature of the effect of the state law on ERISA plans." *Dillingham*, 117 S. Ct. at 838 (quoting *Travelers*, 514 U.S. at 656-656). That inquiry requires preemption here because it is settled that one of ERISA's principal objectives is the elimination of state rules "that risk subjecting plan

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[2] In fact, the court of appeals' description of *Elfstrom* plainly was incorrect; application of the rule has a direct impact on plan administration by dictating the manner in which notice of claims may be provided. Moreover, as we also explain below in connection with the notice-prejudice rule, application of the *Elfstrom* rule requires a departure from the claims procedure that is spelled out in the written plan documents.

administrators to conflicting state regulations." *FMC Corp.*, 498 U.S. at 59.

That risk is apparent here. If agency rules such as the one stated in *Elfstrom* survive, particular actions that are related to plan administration will have radically differing consequences in different jurisdictions. In States that make use of an *Elfstrom* or related rule, the employer's knowledge would be imputed to the insurer, resulting in liability for benefits; in other States, the terms of the plan would govern and liability would *not* attach. As a result, prudent employers that wish to avoid unanticipated liability would have to make use of differing administrative mechanisms in different jurisdictions, or would have to base a nationwide system of administration on the rules of the State that provides for the most expansive system of liability. In either case, the employer would be "required to accommodate conflicting regulatory schemes in devising and operating a system for processing claims and paying benefits — precisely the burden that ERISA pre-emption was intended to avoid." *Fort Halifax*, 482 U.S. at 10. See generally *Pilot Life*, 481 U.S. at 47-48; *Metropolitan Life*, 471 U.S. at 739. This accordingly is a case where "state law intrudes into an area Congress (given ERISA's basic objectives) would have wanted to reserve exclusively for federal legislation." *Boggs*, 117 S. Ct. at 1769 (Breyer, J., dissenting). See *Ingersoll-Rand*, 498 U.S. at 142.

C. The Notice-Prejudice Rule Is Preempted Because It Conflicts With Substantive Provisions of ERISA And Is Not Validated By The Insurance Saving Clause

The court of appeals also erred in its conclusion that the state-law "notice-prejudice" rule survives preemption. In *Cisneros*, the decision whose reasoning was adopted by the court below, the Ninth Circuit appears to have assumed (correctly) that the rule falls within the scope of ERISA's

preemption clause. See 134 F.3d at 943.[3] But the court's reasoning hopped the track when it went on to hold that preemption is vitiated by ERISA's insurance saving clause. The court erred for two independent reasons. Entirely apart from the meaning of the saving clause, the notice-prejudice rule must fall because it directly conflicts with ERISA's substantive provisions. And the court's analysis of the saving clause was, in any event, inconsistent both with this Court's decisions and with fundamental ERISA policy. Again, then, the court of appeals' approach runs directly counter to the interest of plans, of plan sponsors, and of plan beneficiaries.

1. The court of appeals correctly held that the terms of the UNUM disability policy — which is the controlling ERISA plan document in this case — "unambiguously establish that * * * timely submission of proof is a condition precedent to payment of benefits." The court also recognized that "Ward's submission of notice and proof plainly was untimely under the express terms of the UNUM policy." Pet. App. 5a. Having reached that conclusion, however, the court skipped immediately to the question whether the notice-prejudice rule is saved by the insurance saving clause; the court did not pause to consider the possibility that a state-law rule cannot be given force if it requires a court to disregard the terms of a written ERISA plan. That was a fatal oversight.

In fact, this Court has emphasized that ERISA is in substantial part "built around reliance on the face of written plan documents." *Curtiss-Wright*, 514 U.S. at 83. As the Court has explained, one of "ERISA's core functional requirements" is

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[3] As the United States recognizes in its brief in this case, there can be no doubt that the notice-prejudice rule relates to ERISA plans; it requires use of a particular method of administration, setting aside the choice made by the plan sponsor.

> that "[e]very employee benefit plan shall be established and maintained *pursuant to a written instrument*." 29 U.S.C. § 1102(a)(1) (emphasis added). In the words of a key congressional report, "[a] written plan is to be required in order that every employee may, *on examining the plan documents*, determine exactly what his rights and obligations are under the plan." H.R. Rep. No. 93-1280, p. 297 (1974) (emphasis added). ERISA gives effect to this "written plan documents" scheme through a comprehensive set of "reporting and disclosure" requirements * * * .

Ibid. Indeed, "plan administrators appear to have a statutory responsibility actually to run the plan in accordance with the currently operative, governing plan documents." *Id.* at 84. See 29 U.S.C. § 1104(a)(1)(D) (plan administrators have duty to run the plan "in accordance with the documents and instruments governing the plan insofar as such documents and instruments are consistent with the provisions of [ERISA]"). See also 29 C.F.R. § 2560.503-1(d) ("[a] claim [for plan benefits] is filed when the requirements of a reasonable claim filing procedure *of a plan* have been met") (emphasis added).

The California rule at issue here is flatly inconsistent with this central element of ERISA. The federal statute *requires* administrators to implement the provisions of the plan documents, and gives those documents the crucial role in informing employees about both their rights and their obligations. The notice-prejudice rule, on the other hand, authorizes the employee to *disregard* obligations stated in those documents — and would *require* administrators to act in a manner that the documents do not authorize. In these circumstances, "there is a conflict [between ERISA and the state law], which suffices to resolve the case." *Boggs*, 117 S. Ct. at 1760. Whatever the meaning of the preemption and saving clauses, preemption is mandated by "the state law's frustration of congressional intent." *Shaw*, 463 U.S. at 97

n.15. See *Pilot Life*, 481 U.S. at 57; *Alessi*, 451 U.S. at 524.

2. While the existence of a direct conflict with ERISA's substantive provisions means that the saving clause (whatever its proper construction) cannot save California's notice-prejudice rule, it should be added that the court of appeals erred in its understanding of the clause. It is settled that, to determine whether a state law is one regulating insurance for purposes of the saving clause, the Court first takes a "'common-sense view" of the language." *Pilot Life*, 481 U.S. at 48. The Court then looks to the three criteria used to determine whether a practice falls within the "business of insurance" for purposes of the McCarran-Ferguson Act:

> "*First*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry."

Id. at 48-49 (quoting *Union Labor Life Ins. Co.* v. *Pireno*, 458 U.S. 119, 129 (1982)). See *Metropolitan Life*, 471 U.S. at 740-743.

While the Court has held that the presence of a single one of these criteria is *not* sufficient to warrant treatment of a given practice as part of the business of insurance (see *Pilot Life*, 481 U.S. at 51), it *never* has held a state law *to* involve the regulation of insurance unless all of the criteria are present. The Court should not depart from that approach here. That is especially so because all of the relevant considerations actually point *away* from the conclusion that the notice-prejudice rule regulates the business of insurance — meaning that the saving clause cannot apply. Indeed, while the saving clause necessarily countenances a degree of inconsistency in the rules governing insured plans (see, *e.g.*, *Metropolitan Life*, 471 U.S. at 747), the expansive approach

taken to the clause by the court of appeals would subject plans to a virtually limitless and undefined body of state common law, which would cause the very inefficiency, uncertainty, and expense that Congress understood to harm the sound operation of ERISA plans.

First, under a "common sense" approach the notice-prejudice rule does not qualify as an insurance regulation. In holding to the contrary, the court of appeals opined that the rule "is directed specifically at the insurance industry and is applicable only to insurance contracts." *Cisneros*, 134 F.3d at 945. But as petitioner demonstrates (at Br. 27-30), the court was wrong about this as a matter of state law because the rule is only one manifestation of a broader and generally applicable rule of contract law; "it is plain that the [rule] is not limited to entities within the insurance industry." *United States Dep't of the Treasury* v. *Fabe*, 508 U.S. 491, 517 (1993) (Kennedy, J., dissenting). Even if the rule is "identified * * * with the insurance industry," "the roots of the law are firmly planted in the general principles of [California] * * * contract law." *Pilot Life*, 481 U.S. at 50. As a consequence, "a common-sense understanding of the phrase 'regulates insurance' does not support the argument that the [notice-prejudice rule] falls under the saving clause." *Ibid.*

Moreover, courts should be especially cautious when asked to hold that common law tort or contract rules qualify as regulations of insurance within the meaning of ERISA or the McCarran-Ferguson Act. Such rules have nothing in common with considered state statutory or regulatory oversight regarding benefits, rates, insurance reserves, and the like, which were the central congressional concern at the time of the enactment of the McCarran-Ferguson Act. See, *e.g.*, *Group Life & Health Ins. Co.* v. *Royal Drug Co.*, 440 U.S. 205, 217-219 (1979). As the claims in *Pilot Life* and this case illustrate, according the same protection to particular applications of common law rules would invite manipulation

and impossibly fine line-drawing, while giving the McCarran-Ferguson Act and the ERISA insurance saving clause an essentially limitless sweep.

Second, the court of appeals itself acknowledged that the rule "does not spread the policyholder's risk within the meaning of the first McCarran-Ferguson factor." *Cisneros*, 134 F.3d at 946. That conclusion should have been dispositive. "There is general agreement that the primary concerns of an insurance contract are the spreading and the underwriting of risk, * * * and [the Court] ha[s] often recognized this central principle." *Fabe*, 508 U.S. at 511 (Kennedy, J., dissenting). See *Royal Drug*, 440 U.S. at 212, 221 (identifying the "underwriting or spreading of risk as an indispensable characteristic of insurance" and noting that "Congress understood the business of insurance to be the underwriting and spreading of risk"). It is difficult to see how the notice-prejudice rule could be a regulation of the business of insurance when the practice that it regulates "does not involve the transfer of risk from insured to insurer, the type of risk spreading that is the essence of the contract of insurance." *Fabe*, 508 U.S. at 512-513 (Kennedy, J., dissenting).

Third, the court of appeals found that the notice-prejudice rule affected an integral part of the policy relationship between insured and insurer because the rule "effectively creates a mandatory contract term." *Cisneros*, 134 F.3d at 946. On examination, however, the rule's "connection to the insurer-insured relationship is attenuated at best." *Pilot Life*, 481 U.S. at 50-51. Here, the contractual relationship runs directly between the employer and the insurance company, and it is MAC and UNUM that negotiated over contract terms and administrative requirements; the notice-prejudice rule, in contrast, affects a different relationship, that between MAC's covered employees and the insurer. Cf. *Royal Drug*, 440 U.S. at 213-213. Moreover, the rule does not affect "the *substantive* terms of insurance contracts" (*FMC*, 498 U.S. at

61 (emphasis added)) or "the *type* of insurance that an insurer may sell to the policyholder" (*Metropolitan Life*, 471 U.S. at 743 (emphasis added)), and it therefore is doubtful that it can be characterized as "regulat[ing] an *integral* part of the relationship between the insurer and the policyholder" (*ibid.* (emphasis added)); "[i]t does not follow that because an agreement is necessary to provide insurance, it is also the 'business of insurance.'" *Royal Drug*, 440 U.S. at 214 n.9.

Fourth, for reasons already explained, the notice-prejudice rule, "even if associated with the insurance industry, has developed from general principles of * * * contract law available in any [California] * * * contract case." *Pilot Life*, 481 U.S. at 51. For these reasons, the notice-prejudice rule should not be deemed saved by the saving clause.

* * * *

In enacting ERISA, Congress recognized that healthy benefit plans, regulated by predictable and uniform rules, are essential to the economic well-being of tens of millions of employees and other beneficiaries. It acknowledged that such plans are a central component of a sound relationship between companies and their employees. And by providing for the comprehensive federal regulation of welfare and pension benefit plans, it established such plans as important elements in the proper functioning of the national economy.

The approach taken by the court below, however, threatens considerable harm to those interests. It would make inevitable the application to plans of conflicting state standards, creating significant inefficiencies and expense. It would invite continuing litigation about the meaning of varying state standards. And it ultimately would injure beneficiaries by inducing plan sponsors to reduce or eliminate benefits, while creating disincentives for the creation of new plans. This Court should reject that approach, reaffirming its understanding that Congress made an expansive preemption provision a central element of ERISA.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted.

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OCTOBER TERM, 1998

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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INTEREST OF *AMICUS CURIAE*[1]

The National Employment Lawyers Association ("NELA") is a voluntary membership organization of over 3,000 attorneys who regularly represent employees in employment, labor and civil rights disputes. NELA is one of the largest organizations in the United States whose members litigate and counsel individuals on claims arising out of the workplace, including employee benefits claims. NELA has participated as *amicus curiae* in numerous ERISA cases before this Court. These cases include *Geissal v. Moore Medical Corp.*, ___ U.S. ___, 118 S.Ct. 1869 (1998); *Du Buono v. NYSA-ILA Medical and Clinical Services Fund*, 520 U.S. 806 (1997); *Varity Corp. v. Howe*, 516 U.S. 489 (1996); and *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101 (1989).

NELA has an interest in the application of the Employee Retirement Income Security Act ("ERISA") because the clients of NELA members frequently have employee benefits claims. Insurance companies that provide benefits under ERISA plans have sought to use ERISA preemption to avoid state insurance law doctrines which do not favor their interests. However, ERISA was not intended to replace these legal doctrines, such as the notice-prejudice rule. State insurance law doctrines have been applied—and should

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[1] Pursuant to Rule 37.6, *amicus curiae* states that this brief was not authored, in whole or in part, by counsel to a party and that no monetary contribution to the preparation or submission of this brief was made by any person or entity other than the *amicus curiae* or its counsel. This brief is filed with the consent of the parties. Their letters of consent have been filed with the Clerk of the Court.

continue to be applied—to ERISA benefit claims litigation, either under ERISA's Savings Clause or under federal common law.

This case presents the Court with an opportunity to clarify the scope of ERISA's Savings Clause and to confirm that the lower courts have acted properly in adopting state insurance law doctrines.

STATEMENT

The Ninth Circuit found that Respondent's notice and proof of claim were untimely under the express terms of the insurance policy providing benefits under his employer's long-term disability plan. Pet. App. 4a-5a. Nevertheless, the court held that the case should be remanded for further consideration of whether, under California's notice-prejudice rule, Petitioner suffered actual prejudice from the untimely notice. *Id.* at 6a.[2]

In holding that ERISA does not preempt the notice-prejudice rule, the court relied on its decision in *Cisneros v. UNUM Life Ins. Co. of America*, 134 F.3d 939 (9th Cir. 1998), *petition for cert. pending*, No. 97-1867. *Cisneros* held that the California notice-prejudice rule is saved from preemption by ERISA's Savings Clause, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), as a law "which regulates insurance." *Id.* at 945-47. The

[2] In the alternative, the Ninth Circuit held that the case should be remanded to the district court for consideration of whether Respondent's employer acted as Petitioner's agent in administering the plan such that notice of the claim to the employer would be deemed notice to Petitioner under California's *Elfstrom* rule. Pet. App. at 21a-25a. *Amicus curiae* NELA will only address the notice-prejudice issue.

Cisneros court also considered adopting the notice-prejudice rule as federal common law, but rejected this approach. *Id.* at 947.[3]

SUMMARY OF ARGUMENT

Unlike pension plans, ERISA does not contain minimum requirements for welfare benefit plans. In addition, ERISA saves state laws "which regulate insurance" from preemption under the Savings Clause. ERISA § 514(b)(2)(A). Welfare benefit plans generally provide benefits through insurance policies. Congress intended that the interpretation of these ERISA plan insurance policies would be guided by state insurance law doctrines, consistent with the McCarran-Ferguson Act.

Thus, the federal courts have frequently looked to state insurance law for rules of decision in ERISA cases, either under the Savings Clause or as a source for federal common law. Although Petitioner predicts that the administration of ERISA plan insurance policies will be disrupted if state insurance law is applied to ERISA benefit claims, numerous state insurance law doctrines—including several of the specific examples cited by Petitioner—have already been used as rules of decision in ERISA cases without any such disruption. In some cases, insurance companies themselves have urged the courts to adopt state insurance law under ERISA.

[3] An earlier panel decision held that California's notice-prejudice rule applied under both the Savings Clause and as federal common law. 115 F.3d 669 (9th Cir. 1997), *withdrawn*, 134 F.3d 939 (9th Cir. 1998).

This Court should clarify that state laws regulating the terms and interpretation of an insurance policy are not preempted by ERISA, and confirm that the application of state insurance law doctrines is in keeping with Congress' expectation that the courts will develop a "federal common law of rights and obligations under ERISA-regulated plans." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989) (citing 129 Cong. Rec. 29942 (1974) (remarks of Sen. Javits)) (other citations omitted).

ARGUMENT

I. THE FEDERAL COURTS HAVE APPLIED MANY STATE INSURANCE LAW DOCTRINES TO ERISA WELFARE BENEFIT CLAIMS, AND SHOULD CONTINUE TO LOOK TO STATE INSURANCE LAW FOR RULES OF DECISION IN ERISA CASES.

The Employee Retirement Income Security Act (ERISA), 29 U.S.C. § 1001 *et seq.*, does not contain any substantive requirements for employee welfare benefit plans. Unlike pension benefit plans, welfare benefit plans are not subject to participation, vesting or benefit accrual rules under ERISA. *See* ERISA §§ 201 - 204, 29 U.S.C. §§ 1051 - 1054. In addition, most welfare benefit plans provide benefits through group insurance policies. (*See* Brief for Petitioner at fn. 9.) Because of the lack of statutory guidance in ERISA, the Savings Clause, and the longstanding regulation of insurance under state law pursuant to the McCarran-Ferguson Act, 15 U.S.C. § 1012, the federal courts have turned to state insurance law doctrines for rules of decision in ERISA welfare benefit claims litigation.

A. State Insurance Law Doctrines Apply to ERISA Welfare Benefit Claims under ERISA's Savings Clause or as a Matter of Federal Common Law.

Contrary to Petitioner's assertion, the Court of Appeals did not open a Pandora's Box in holding that the notice-prejudice rule applies to a claim for benefits under an ERISA plan. The federal courts have for many years applied state insurance law doctrines to ERISA welfare benefit claims, either under ERISA's Savings Clause or under federal common law.

The state insurance law doctrines which have been used to decide ERISA benefit claims include the *contra proferentem* doctrine whereby ambiguous terms in insurance policies are construed against the insurer which drafted the policy; the allocation of the burden of proof and evidentiary presumptions; coordination of benefits rules; and rescission of the insurance policy based on fraudulent or material misrepresentation by the insured. Seen in this light, the Court of Appeals' holding that the California notice-prejudice rule applies to an ERISA welfare benefit plan insurance policy is merely an extension of well-established ERISA case law.

Petitioner includes several of these state insurance law doctrines in its "parade of horribles" which they claim will follow if the Ninth Circuit's ruling is upheld. (Brief for Petitioner at 47.) Despite Petitioner's dire predictions, ERISA welfare benefit plans have been subject to state insurance law doctrines for many years and still the sky has not fallen. Ironically, insurance companies themselves have frequently urged the courts to rescind ERISA plan insurance policies based on state insurance law doctrines.

Most of the courts which have applied these state insurance law doctrines have done so by adopting the doctrines as federal common law. When Congress enacted ERISA, it was not writing on a clean slate. *See Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-85 (1988). "Congress is understood to legislate against a background of common law adjudicatory principles. . . . Thus, where a common-law principle is well-established . . . the court may take it as given that Congress has legislated with an expectation that the principles will apply except when a statutory purpose to the contrary is evident." *Astoria Fed. Sav. and Loan Ass'n v. Solimino*, 501 U.S. 104, 108 (1991) (internal quotations omitted).

The common law includes numerous rules of decision for insurance disputes. By creating an exception to preemption for state insurance law and by not enacting substantive rules for employee welfare benefit plans, Congress legislated with the expectation that the federal courts would apply state insurance law principles to ERISA welfare benefit claims. Thus, the application of state insurance law doctrines is in keeping with the congressional expectation that the courts will develop a "federal common law of rights and obligations under ERISA-regulated plans." *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 110-11 (1989) (citing 129 Cong. Rec. 29942 (1974) (remarks of Sen. Javits)) (other citations omitted).

In the decision below and in other cases, the courts have held that state insurance laws are saved from preemption by ERISA's Savings Clause, ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A), and therefore followed insurance law doctrines as applicable state law. *Amicus*

curiae agrees with Respondent's position that a state insurance law, such as California's notice-prejudice rule, is not preempted by ERISA if it meets this Court's "common-sense" test of regulating insurance.

The lower courts' uncertainty regarding the scope of the Savings Clause following this Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), has led courts in some instances to adopt state insurance law doctrines as federal common law under ERISA rather than applying the state laws directly under the Savings Clause. This case presents this Court with an opportunity to clarify that state laws regulating the terms and interpretation of an insurance policy are not preempted by ERISA.

Whether the basis for applying state insurance law doctrines is the Savings Clause or federal common law, the underlying reasoning is the same—employees who are insured by an ERISA plan group insurance policy should have the same coverage as individuals who are covered by the identical insurance policy outside the context of an ERISA plan. Policy interpretation (as opposed to civil enforcement remedies) should not depend upon whether the insurance policy is issued to an ERISA plan or some other insured.

B. Contrary to Petitioner's Brief, Affirmance of the Court of Appeal's Decision Will Not Have a Significant Effect upon ERISA Plans Because Such Plans Are Already Subject to Numerous State Insurance Law Doctrines.

Petitioner's Brief presents an inaccurate portrait of the landscape of current ERISA law. Petitioner would have this Court believe that state insurance law doc-

trines are anathema to ERISA benefit claims. But, as shown below, the courts have applied many state insurance law doctrines to ERISA welfare benefit claims, either under ERISA's Savings Clause or under federal common law.

1. *Contra Proferentem*

In *Kunin v. Benefit Trust Life Ins. Co.*, 910 F.2d 534, 539-41 (9th Cir.), *cert. denied*, 498 U.S. 1013 (1990), the Ninth Circuit held that the rule of *contra proferentem* applies to an ambiguous term in an ERISA plan insurance contract. Under *contra proferentem*, ambiguous terms are interpreted in favor of providing coverage to the insured. The *Kunin* court stated that the doctrine applied to ERISA plan insurance policies either as a state insurance law saved from preemption or as federal common law. *Id.* at 539-40.

Following *Kunin,* almost every circuit has held that the rule of *contra proferentem* applies to ERISA plans maintained pursuant to an insurance contract.[4] The

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[4] *Hughes v. Boston Mutual Life Ins. Co.*, 26 F.3d 264, 268 (1st Cir. 1994); *Masella v. Blue Cross & Blue Shield of Conn., Inc.*, 936 F.2d 98, 107 (2d Cir. 1991); *Heasley v. Belden & Blake Corp.*, 2 F.3d 1249, 1257-58 (3d Cir. 1993); *Glocker v. W.R. Grace & Co.*, 974 F.2d 540, 544 (4th Cir. 1992); *Todd v. AIG Life Ins. Co.*, 47 F.3d 1448, 1451-52 (5th Cir. 1995); *McNeilly v. Bankers United Life Assurance Co.*, 999 F.2d 1199, 1201 (7th Cir. 1993); *Delk v. Durham Life Ins. Co.*, 959 F.2d 104, 106 (8th Cir. 1992); *Lee v. Blue Cross/Blue Shield of Alabama*, 10 F.3d 1547, 1551 (11th Cir. 1994). *But see Brewer v. Lincoln National Life Ins. Co.*, 921 F.2d 150, 153-54 & n.2 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991) (rejecting *Kunin*); *McMahan v. New England Mutual Life Ins. Co.*, 888 F.2d 426, (continued...)

First, Second, Third, Fourth, Fifth, Seventh, Eighth, and Eleventh Circuits have adopted *contra proferentem*, either as federal common law or without stating whether the Savings Clause or federal common law provided the basis for adopting the rule.

Petitioner cites *McMahan v. New England Mutual Life Ins. Co.*, 888 F.2d 426, 429-30 (6th Cir. 1989) (Petitioner's Brief at fn. 10), but, as demonstrated by the cases cited below, the Sixth Circuit stands alone in rejecting the *contra proferentem* doctrine under ERISA. (Petitioner also cites *Brewer v. Lincoln National Life Ins. Co.*, 921 F.2d 150, 153-54 & n.2 (8th Cir. 1990), *cert. denied*, 501 U.S. 1238 (1991), which declines to follow *Kunin* (Petitioner's Brief at fn. 10), but the Eighth Circuit later held that *contra proferentem* should be applied to ambiguous terms in ERISA plan insurance policies when no common-sense meaning is evident. *Delk v. Durham Life Ins. Co.*, 959 F.2d 104, 106 (8th Cir. 1992).)

2. Allocation of the Burden of Proof and Evidentiary Presumptions.

In deciding claims arising under ERISA welfare benefit plan insurance contracts, the courts have also looked to state insurance law doctrines establishing the burden of proof and evidentiary presumptions. Thus, several circuits have applied the "basic rule of insurance law that the insured carries the burden of showing a covered loss has occurred and the insurer must prove

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[4] (...continued)
429-30 (6th Cir. 1989) (*contra proferentem* under state law preempted by ERISA).

facts that bring a loss within an exclusionary clause of the policy" as a rule of decision for ERISA claims. *McGee v. Equicor-Equitable*, 953 F.2d 1192, 1205 (10th Cir. 1992).[5]

Petitioner cites the California insurance law rule allocating the burden of proof for exclusionary clauses to the insurer and asserts that this rule would disrupt the administration of ERISA plans if the decision below is upheld. (Petitioner's Brief at 47.) However, as shown by the cases cited below, this rule has already been adopted by four circuits as a rule of decision for ERISA benefit claims. Similarly, in deciding an ERISA claim under an accidental death policy, the Eleventh Circuit adopted the state insurance law presumption against suicide and in favor of accidental death. *Horton v. Reliance Standard Life Ins. Co.*, 141 F.3d 1038, 1041 (11th Cir. 1998).

3. Coordination of Benefits Rules.

In *PM Group Life Ins. v. Western Growers Assur. Trust*, 953 F.2d 543 (9th Cir. 1992) (Kozinski, J.), both parents of a premature infant had medical coverage through ERISA plans; however, the plans had inconsistent coordination of benefits rules and disputed which plan would provide primary coverage. Since both plans were self-funded, the court held that they were not subject to state insurance regulation under the "deemer clause," ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B), and ERISA therefore preempted the coordination of benefits regulation in the California administrative code. *Id.* at 545-46. In *dicta*, the court noted that state insurance law would govern the interpretation of coordination of benefits rules in cases where both ERISA plans are insured. *Id.* at 548 fn. 6.

[5] *See also, Blair v. Metropolitan Life Ins. Co.*, 974 F.2d 1219, 1220-21 (10th Cir. 1992) (insurer failed to meet its burden of proving that insured's treatment was a "dental service" under ERISA-governed policy exclusionary clause); *Santaella v. Metropolitan Life Ins. Co.*, 123 F.3d 456, 461 (7th Cir. 1997); *Jenkins v. Montgomery Indus., Inc.*, 77 F.3d 740, 743 (4th Cir. 1996); *Farley v. Benefit Trust Life Ins. Co.*, 979 F.2d 653, 658 (8th Cir. 1992); *Cleary v. Knapp Shoes, Inc.*, 924 F.Supp. 309, 315-17 (D.Mass. 1996) (plan administrator had burden of proving that a covered injury fell within an exclusion provision).

In deciding the benefit claim, the court fashioned an appropriate coordination of benefits rule as a matter of federal common law. Relying on the National Association of Insurance Commissioners (NAIC) Model Regulations, the court adopted "the birthday rule," which places primary liability on the plan of the employee whose birthday falls earlier in the year. *Id.* at 547-48.

In *McGurl v. Trucking Employees of North Jersey Welfare Fund*, 124 F.3d 471 (3d Cir. 1997), the Third Circuit took a similar approach to a conflict between the "other insurance" provisions of two self-funded ERISA plans, each of which purported to provide at most secondary coverage to employees who were covered under both plans. The Third Circuit adopted the "employer first" rule in the NAIC Model Regulations—which had been adopted (at least in part) by 39 states—providing that the plan covering the person as an employee pays benefits first. The plan covering the same person as a dependent pays benefits second. *Id.* at 483-84.

By applying coordination of benefit rules such as the "birthday rule" and the "employer first" rule, the courts

effectively modify the terms of ERISA plans by adding an implied rule adopted from state insurance laws. Moreover, many of the other state insurance law doctrines which have been applied in ERISA cases also have the effect of adding an implied term to an ERISA plan insurance policy. Petitioner therefore is mistaken in asserting that "the Courts of Appeals have consistently held that ERISA bars the use of any common-law doctrines which . . . cause a departure from the written plan document." (Brief for Petitioner at 34.)

Insurance policies—like other ERISA plan documents—must comply with the provisions of ERISA. ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D). Thus, insurance provisions such as state-mandated benefits or coordination of benefit rules which are recognized under ERISA's Savings Clause or the federal common law of ERISA are implied plan terms even where they have been omitted from the policy.

4. Rescission Based on Fraudulent or Material Misrepresentation.

Although plan participants and beneficiaries typically urge courts to import state insurance law into ERISA disputes, there is at least one area in which insurance companies make the same argument—cases in which an insurance company seeks to rescind an ERISA-governed insurance policy based upon alleged misrepresentations made by the insured in his or her application. Since ERISA is silent on this issue, insurance companies have argued that the courts should apply the rescission statutes in state insurance codes or adopt the same rules as federal common law. Thus, it is puzzling that Petitioner includes rescission statutes from the California

Insurance Code in its "parade of horribles" which will follow if the decision below is upheld. (Brief for Petitioner at 47.)

The courts have looked to state insurance law in fashioning a federal common law doctrine permitting an ERISA plan insurer to rescind an insurance policy if the insured has made a fraudulent or material misrepresentation. In *Davies v. Centennial Life Ins. Co.*, 128 F.3d 934 (6th Cir. 1997), the Sixth Circuit held that the Ohio statute permitting the rescission of insurance policies in such instances was preempted by ERISA. However, the Sixth Circuit adopted essentially the same rule as a matter of federal common law. *Id.* at 943. *See also, Tingle v. Pacific Mutual Insurance Co.*, 996 F.2d 105, 109 (5th Cir. 1993); *Security Life Ins. Co. v. Meyling*, 146 F.3d 1184 (9th Cir. 1998); *Hauser v. Life General Sec. Ins. Co.*, 56 F.3d 1330, 1335 (11th Cir. 1995) (assuming right of rescission exists under ERISA-created federal common law).[6]

CONCLUSION

The Ninth Circuit's adoption of the California notice-prejudice rule for ERISA benefit claims is consistent with well-established precedent. The rule is merely one of many state insurance law doctrines which the courts

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[6] The doctrines discussed above are by no means an exhaustive list of the state insurance law doctrines which have been applied in ERISA benefit claim litigation. For example, two circuits have adopted the "reasonable expectations" doctrine. *Wheeler v. Dynamic Engineering, Inc.*, 62 F.3d 634, 638 (4th Cir. 1995); *Saltarelli v. Bob Baker Medical Trust*, 35 F.3d 382, 386 (9th Cir. 1994).

have applied in deciding ERISA benefit claims, either under ERISA's Savings Clause or under federal common law.

The states have regulated insurance for more than 50 years following the passage of the McCarran-Ferguson Act, and the common law of insurance has developed over the course of centuries. The courts should not throw away this jurisprudence in deciding benefit claims under ERISA. Congress expressed its intention that state insurance law doctrines would remain in force by saving state insurance laws from preemption, directing the courts to develop a federal common law of ERISA, and omitting substantive requirements for welfare benefit plans from the statute.

In the event that the Court holds that California's notice-prejudice rule is not saved by the insurance savings clause, the Court should make clear that the courts could adopt a similar rule as a matter of federal common law under ERISA.

For the foregoing reasons, *amicus curiae* NELA respectfully urges that the Court affirm the decision of the Court of Appeals.

Respectfully submitted,

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IN THE
Supreme Court of the United States
OCTOBER TERM, 1998

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Writ of Certiorari to the United States Court of Appeals for the Ninth Circuit

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BRIEF OF THE COUNCIL OF STATE GOVERNMENTS, NATIONAL GOVERNORS' ASSOCIATION, NATIONAL ASSOCIATION OF COUNTIES, NATIONAL LEAGUE OF CITIES, U.S. CONFERENCE OF MAYORS, AND INTERNATIONAL CITY/COUNTY MANAGEMENT ASSOCIATION AS *AMICI CURIAE* SUPPORTING RESPONDENT

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QUESTIONS PRESENTED

1. Whether California's notice-prejudice rule is a state law saved from preemption by ERISA's saving clause.

2. Whether California's *Elfstrom* rule is a state law saved from preemption by ERISA's saving clause.

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INTEREST OF THE *AMICI CURIAE*

Amici are organizations whose members include state, county and municipal governments and officials throughout the United States.[1] *Amici* have a compelling interest in the extent to which the ERISA saving clause preserves the States' traditional power to regulate insurance.

For one hundred fifty years the regulation of insurance has been the responsibility of the States. Congress expressly preserved this exercise of the States' historic police powers in the McCarran-Ferguson Act and reaffirmed it thirty years later in ERISA's saving clause. Petitioner and its *amici* urge upon this Court an untenably narrow reading of ERISA's saving clause that is plainly contrary to Congress' intent and interferes with the States' authority to regulate insurance.

Because of the importance of the issues presented to the ability of the States to exercise one of the core components of their regulatory authority, *amici* submit this brief to assist the Court in the resolution of this case.

SUMMARY OF ARGUMENT

1. As this Court has long recognized, the regulation of insurance is a classic exercise of the States' historic police powers. Congress expressly authorized state regulation of insurance both in 1945, when it enacted the McCarran-Ferguson Act, and in 1974, by ERISA's saving clause.

ERISA expressly saves from preemption "any law of any State which regulates insurance." 29 U.S.C. § 1144 (b)(2)(A). In applying the saving clause, the Court uses a two-part test. The first part asks whether, as a matter of "common-sense," the law is "specifically directed toward

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[1] Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief *amicus curiae*. Their letters of consent have been filed with the Clerk of the Court.

Pursuant to Rule 37.6 of the Rules of this Court, *amici* state that this brief was not authored in whole or in part by counsel for a party, and no person or entity, other than the *amici* or their members, made a monetary contribution to the preparation or submission of this brief.

[the insurance] industry." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987). The Court next considers the three factors identified in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 129 (1982). It does so, however, only to verify the "common-sense" conclusion that a state law regulates insurance. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 743 (1985). The Court has never mandated that the three *Pireno* factors even be considered, much less each be satisfied, to save a state insurance law from preemption by ERISA.

The conclusion that rigid adherence to the three *Pireno* factors is not required in ERISA saving clause analysis is supported by the Court's treatment of the very similar saving provision in the first clause of section 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b). In *Department of Treasury v. Fabe*, 508 U.S. 491 (1993), the Court held that cases interpreting the second clause of section 2(b) relating to the business of insurance, such as *Pireno*, do not control in cases arising under the first clause which relates to state insurance regulation. *Fabe* therefore plainly undercuts UNUM's argument that the *Pireno* factors play a larger role in applying ERISA's saving clause than they do under the first clause of section 2(b) of McCarran-Ferguson, upon which the ERISA saving clause was modeled.

2. California's notice-prejudice rule, which prohibits an insurer from denying coverage because of late notice unless the insurer can demonstrate that it will be substantially prejudiced, is saved from preemption by the ERISA saving clause. First, it fully satisfies the "common-sense" requirement that it be a law "specifically directed toward [the insurance] industry." *Pilot Life*, 481 U.S. at 50. The many state laws on this subject demonstrate that when state courts and legislatures address the legal significance of the timing of notice under insurance policies, they are regulating insurance specifically and not simply applying general contract principles.

Second, consideration of the *Pireno* factors supports the conclusion that the notice-prejudice rule "regulates insurance" under ERISA's saving clause. The notice-prejudice rule is obviously an "integral part of the policy relationship between the insurer and the insured." *Pilot Life*, 481 U.S. at 48-49 (quoting *Pireno*, 458 U.S. at 129). It is also "limited to entities in the insurance industry." *Id.*

Because a state law need not satisfy all three *Pireno* factors in order to be saved from preemption by ERISA, this Court could hold that the notice-prejudice rule is saved without regard to whether it satisfies *Pireno*'s risk-spreading factor. In any event, the court of appeals' conclusion that the notice-prejudice rule does not spread risk is incorrect. The rule does in fact spread risk by requiring the insurer to provide coverage for an occurrence that would not otherwise be covered because the claim was not made within the time limit set forth in the policy.

Finally, UNUM's argument that the notice-prejudice rule is preempted because it conflicts with ERISA is without merit. The notice-prejudice rule does not conflict with ERISA's civil enforcement scheme or with any of the statute's other provisions.

3. In *Elfstrom v. New York Life Ins. Co.*, 432 P.2d 731, 737 (Cal. 1967), the California Supreme Court announced the rule of insurance law that "the employer is the agent of the insurer in performing the duties of administering group insurance policies." *Elfstrom* rejected the traditional rule that made the employer the agent of employees covered by group insurance plans. As a matter of fairness, *Elfstrom* places upon the insurer the cost of employer mistakes in administering group insurance policies.

The *Elfstrom* rule is a state law that regulates insurance by requiring the performance of the insurance contract even when the employer makes mistakes that might otherwise excuse performance by the insurer under the terms of the policy. *Elfstrom* satisfies both the "common-sense" test for a state law that regulates insurance and each of the three *Pireno* criteria. It is also consistent with ERISA's other provisions, including its fiduciary rules. It is accordingly saved from preemption by ERISA's saving clause.

ARGUMENT

I. A STATE LAW THAT REGULATES INSURANCE CAN BE SAVED FROM PREEMPTION UNDER ERISA WITHOUT SATISFYING ALL THREE *PIRENO* FACTORS

A. ERISA's Saving Clause Reaffirms The National Policy Of Making Insurance Regulation The Responsibility Of The States

The regulation of insurance is a classic exercise of the States' historic police powers. *See, e.g., SEC v. Variable Annuity Life Ins. Co.*, 359 U.S. 65, 68-69 (1959) ("When the States speak in the field of 'insurance,' they speak with the authority of a long tradition."); *Northwestern Nat'l Life Ins. Co. v. Riggs*, 203 U.S. 243, 254 (1906). "Since 1851 the several states, spurred by necessity and with acquiescence of every branch of the Federal Government, have been building up systems of regulation to discharge this duty toward their inhabitants." *United States v. South-Eastern Underwriters Ass'n*, 322 U.S. 533, 584 (1944) (Jackson, J., dissenting).

Congress expressly authorized this exercise of the States' police powers when, in 1945, it enacted the McCarran-Ferguson Act. McCarran-Ferguson declares the national policy that "the continued regulation and taxation by the several States of the business of insurance is in the public interest." 15 U.S.C. § 1011. *See also id.* § 1012(b) ("No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance . . . unless such Act specifically relates to the business of insurance."). Congress took this action with

> full knowledge of the nation-wide existence of state systems of regulation and taxation; [and] of the fact that they differ greatly in the scope and character of the regulations imposed. . . . Congress could not have been unacquainted with these facts and its purpose was evidently to throw the whole weight of its power

> behind the state systems, notwithstanding these variations.

Prudential Ins. Co. v. Benjamin, 328 U.S. 408, 430 (1946).

The national policy of committing the regulation of insurance to the States was reaffirmed in ERISA. ERISA's saving clause, 29 U.S.C. § 1144(b)(2)(A), expressly exempts from preemption "any law of any State which regulates insurance" in wording similar to that of § 2(b) of McCarran-Ferguson. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 744 n.21 (1985). The Court has recognized that the ERISA saving clause, like the McCarran-Ferguson Act, necessarily results in variations in law from State to State, but that "[s]uch disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Id.* at 747.

B. ERISA's Saving Clause Does Not Require That All Three *Pireno* Factors Be Satisfied

In *Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119 (1982), this Court identified three factors that are used to determine whether a business practice is part of the business of insurance and is therefore exempt from the antitrust laws under § 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b):

> [*F*]*irst*, whether the practice has the effect of transferring or spreading a policyholder's risk; *second*, whether the practice is an integral part of the policy relationship between the insurer and the insured; and *third*, whether the practice is limited to entities within the insurance industry.

458 U.S. at 129; *see also Group Life & Health Ins. Co. v. Royal Drug Co.*, 440 U.S. 205, 212-18 (1979). This Court's decisions interpreting ERISA's saving clause also consider these factors. *See Metropolitan Life*, 471 U.S. at 742-43; *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50-51 (1987).

The starting point in analyzing the proper use of the *Pireno* factors in this case is the terms of ERISA itself.

Section 514(a) preempts state laws that "relate to" employee benefit plans. 29 U.S.C. § 1144(a). Section 514(b)(2)(A), however, ensures that "nothing in [ERISA's employee benefits rights provisions] shall be construed to exempt or relieve any person from any law of any State which regulates insurance." 29 U.S.C. § 1144(b)(2)(A). This saving clause is designed to protect traditional state regulatory powers from preemption. As this Court explained in *New York State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*:

> [W]e have never assumed lightly that Congress has derogated state regulation, but instead have addressed claims of pre-emption with the starting presumption that Congress does not intend to supplant state law. Indeed, in cases like this one, where federal law is said to bar state action in fields of traditional state regulation, we have worked on the "assumption that the historic police powers of the States were not to be superseded by the Federal Act unless that was the clear and manifest purpose of Congress."

514 U.S. 645, 654-55 (1995) (quoting *Rice v. Santa Fe Elevator Corp.*, 331 U.S. 218, 230 (1947)) (other citations omitted); *see also Fort Halifax Packing Co., Inc. v. Coyne*, 482 U.S. 1, 19 (1987) ("ERISA pre-emption analysis 'must be guided by respect for the separate spheres of governmental authority preserved in our federalist system.'") (quoting *Alessi v. Raybestos-Manhattan, Inc.*, 451 U.S. 504, 522 (1981)).

In construing ERISA's saving clause, this Court uses a "common-sense" test: "[A] law must not just have an impact on the insurance industry, but must be specifically directed toward that industry" to qualify as a law regulating insurance. *Pilot Life*, 481 U.S. at 50; *see also id.* (concluding that "a common-sense understanding of the phrase 'regulates insurance' does not support the argument that the Mississippi law of bad faith falls under the saving clause"); *Metropolitan Life*, 471 U.S. at 740.

This Court has also consulted the *Pireno* factors in ERISA cases, but it does so only to verify the "common-sense" conclusion that a state law "regulates insurance." *Pilot Life*, 481 U.S. at 50; *see also id.* at 49 (noting that the "considerations weighed" under the *Pireno* factors "argue against the assertion that the Mississippi law of bad faith is a state law that 'regulates insurance'"); *Metropolitan Life*, 471 U.S. at 743 (characterizing the *Pireno* factors as "criteria relevant" and noting that "[a]pplication of [the *Pireno* factors] suggests that mandated-benefit laws are state regulation of the 'business of insurance'"). Although UNUM urges otherwise, this Court has never mandated that the *Pireno* factors must be considered, much less met, to save a state law under ERISA. *Cf. FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990) (state anti-subrogation provision is a state law which regulates insurance under ERISA's saving clause without any reference to the *Pireno* factors).

Mandatory application of any *Pireno* factor is also unnecessary because the common-sense approach to preemption suggests one last consideration that would not be necessary if the common-sense test were subject to the rigid analysis UNUM urges the Court to undertake. *Pilot Life* suggests an additional inquiry, beyond application of the *Pireno* factors, that courts should conduct. This inquiry asks whether the state law at issue comports with "the role of the saving clause in ERISA as a whole." *Pilot Life*, 481 U.S. at 51 (stating "we are obliged in interpreting the saving clause to consider not only the factors by which we were guided in *Metropolitan Life*, but also the role of the saving clause in ERISA as a whole"). *See id.* at 57. This safety valve—requiring preemption of state laws that otherwise may meet the "common-sense" test—would be unnecessary if all three *Pireno* factors had to be met before a state law could even qualify as a law regulating insurance.

That this Court did not intend to rigidly require the *Pireno* factors to be met to save a state law from ERISA preemption is also strongly supported by a comparison with this Court's treatment of the similar saving provision

in the McCarran-Ferguson Act.[2] This Court has specifically recognized the parallel goals of the McCarran-Ferguson Act and ERISA's saving clause:

> The ERISA saving clause, with its similarly worded protection of "any law of any State which regulates insurance," appears to have been designed to preserve the McCarran-Ferguson Act's reservation of the business of insurance to the States. The saving clause and the McCarran-Ferguson Act serve the same federal policy and utilize similar language to define what is left to the States.

Metropolitan Life, 471 U.S. at 744 n.21.

This Court's analysis under the first clause of § 2(b) of the McCarran-Ferguson Act—the clause preserving state laws "regulating the business of insurance"—is relevant here because it closely parallels ERISA's saving clause language, which preserves any state law which regulates insurance. *See id.*; 29 U.S.C. § 1144(b)(2)(A). In *Department of Treas. v. Fabe*, 508 U.S. 491, 504-06 (1993), this Court reasoned that cases implicating the second clause of § 2(b) do not control in cases arising under the first clause. Specifically, this Court made clear that analysis under the first clause of § 2(b) is not so "narrowly circumscribed" as is analysis under the second clause because "[t]o equate laws 'enacted . . . for the purpose of regulating the business of insurance' with the 'business of insurance' itself . . . would be to read words

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[2] ERISA's saving clause is modeled after § 2(b) of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b), which also saves state insurance regulation from preemption. Section 2(b) of the McCarran-Ferguson Act provides in pertinent part:

> No Act of Congress shall be construed to invalidate, impair, or supersede any law enacted by any State for the purpose of regulating the business of insurance, . . . unless such Act specifically relates to the business of insurance: Provided, That . . . [the federal antitrust statutes] shall be applicable to the business of insurance to the extent that such business is not regulated by State Law.

15 U.S.C. § 1012(b).

out of the statute. This we refuse to do." *Id.* at 504.[3] The Court further explained that "[t]he broad category of laws enacted 'for the purpose of regulating the business of insurance' . . . necessarily encompasses more than just the 'business of insurance.'" *Id.* at 505.

Accordingly, the *Fabe* Court concluded that an Ohio statute that required distribution of an insolvent insurance company's assets to policyholders in preference to other creditors, including the United States, "'regulat[es] the business of insurance' to the extent that it serves to ensure that . . . policyholders ultimately will receive payment on their claims." *Id.* at 506 (quoting 15 U.S.C. § 1012(b)). The Court therefore purposefully took a broader view of what constitutes the regulation of the "business of insurance" under the first clause of the McCarran-Ferguson Act saving provision than it did when it determined what constitutes the "business of insurance" as the term is used in the second clause of the same Act in *Royal Drug* and *Pireno*. *Fabe* therefore plainly undercuts UNUM's argument that the *Pireno* factors play a larger role in applying the ERISA saving clause than they do under the first clause of section 2(b) of the McCarran-Ferguson Act, the very statute upon which the ERISA saving clause was modeled.

This Court's analysis in *Fabe* reinforces the conclusion that the *Pireno* factors are not dispositive of the issue of whether a state law "regulates insurance" for purposes of ERISA's saving clause. Indeed, the case for a more limited role for the *Pireno* factors is even stronger in the ERISA context than under McCarran-Ferguson because ERISA uses language that is more expansive than the language used in the first clause of McCarran-Ferguson

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[3] One commentator concludes that "courts resolving questions of the scope of ERISA's saving clause should apply the broader construction of the phrase 'business of insurance' as directed by *Fabe*," rather than rigidly applying the *Pireno* factors. Karen A. Jordan, *ERISA Preemption: Integrating* Fabe *Into The Saving Clause Analysis*, 27 Rutgers L.J. 273, 311 (1996).

construed in *Fabe*.[4] Accordingly, a state law need not satisfy all three *Pireno* factors in order to be saved from preemption by ERISA.[5]

II. CALIFORNIA'S NOTICE-PREJUDICE RULE IS SAVED FROM PREEMPTION

The notice-prejudice rule precludes an insurer from denying coverage because of late notice under the terms of the policy unless the insurer can demonstrate that it will be substantially prejudiced if the notice provision is not enforced as written. *See, e.g., Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 15 Cal. Rptr. 2d 815, 845 (Ct. App. 1993). Applying this Court's common-sense test, informed by consideration of the *Pireno* factors and the underlying goals of the saving clause, this Court should hold that the notice-prejudice rule is not preempted by ERISA.

A. The Notice-Prejudice Rule Meets The Common-Sense Definition Of A Law Regulating Insurance

A "common-sense" definition of a law regulating insurance requires that "a law must not just have an impact

[4] The ERISA saving clause, by its terms, applies to "any law of any State which regulates insurance," 29 U.S.C. § 1144(b)(2)(A), while the first clause of § 2(b) of the McCarran-Ferguson Act applies to laws which have the "purpose of regulating the business of insurance." 15 U.S.C. § 1012(b).

[5] UNUM's argument for a strict application of the *Pireno* factors assumes that *Pireno* itself requires that all three factors must be met in the antitrust immunity context. *See* Pet. Br. 24-26. This assumption, however, finds no basis in any of this Court's antitrust immunity cases because the Court has only considered cases in which none of the factors was met. *See Pireno*, 458 U.S. at 130-33 (holding that none of the three factors was satisfied); *Royal Drug*, 440 U.S. at 212-17 (same).

Indeed, the language in *Pireno* suggests the opposite conclusion: this Court referred to the three factors as "*criteria relevant* in determining whether a particular practice is part of the 'business of insurance' exempted from the antitrust laws by § 2(b)." *Pireno*, 458 U.S. at 129 (emphasis added). Moreover, the Court emphasized in *Pireno* that "[n]one of these criteria is necessarily determinative in itself." *Id.* The Court's language is inconsistent with a view that the *Pireno* factors comprise a rigid test under which each element is dispositive.

on the insurance industry, but must be specifically directed toward that industry." *Pilot Life*, 481 U.S. at 50. The notice-prejudice rule fully meets this test. Indeed, a survey of state law on the enforceability of notice provisions in insurance contracts demonstrates that when state courts and legislatures consider this issue, they are regulating insurance specifically and not simply applying general contract principles in an insurance context.

Almost every State has an insurance rule or statute that dictates whether a notice-forfeiture provision in an insurance contract is enforceable without showing prejudice. California follows the majority view that an insurer must show prejudice to deny coverage because of late notice.[6] The California Supreme Court has determined that "[a]n insurer may assert defenses based upon a breach by the

[6] Alaska, Arizona, California, Delaware, Hawaii, Kansas, Kentucky, Maine, Michigan, Minnesota, Missouri, Montana, Nebraska, New Hampshire, New Jersey, New Mexico, North Dakota, Oklahoma, Oregon, Pennsylvania, Rhode Island, South Carolina, Washington, and West Virginia require that the insurer demonstrate prejudice in order to deny benefits because of late notice. *See* Eugene R. Anderson *et al.*, *Draconian Forfeitures of Insurance: Commonplace, Indefensible, and Unnecessary*, 65 Fordham L. Rev. 825, 862-69 (1996) (collecting cases and statutes). In addition, Maryland, Massachusetts, and Wisconsin have notice-prejudice statutes. *See* Md. Code Ann., Ins., § 19-110; Mass. Gen. L. ch. 175, § 112; Wis. Stat. § 631.81. *See also* Kathleen E. Wherthey, *Survey: Developments in Maryland Law, 1992-93*, 53 Md. L. Rev. 948, 951 & n.30 (1994); Charles M. Marvel, Annotation, *Modern Status of Rules Requiring Liability Insurer to Show Prejudice to Escape Liability Because of Insured's Failure or Delay in Giving Notice of Accident or Claim, or in Forwarding Suit Papers*, 32 A.L.R. 4th 141 (1981); Barry R. Ostrager & Thomas R. Newman, *Handbook on Insurance Coverage Disputes* § 4.02[c][2], at 109-10 (8th ed. 1995) (collecting cases adhering to the "emerging majority view" that late notice does not relieve the insurer of its obligations unless the delay prejudices the insurer); Robert E. Keeton & Alan I. Widiss, *Insurance Law: A Guide to Fundamental Principles, Legal Doctrines, and Commercial Practices* § 7.2, at 763 (1988) (noting that "there is something approaching a consensus in regard to the general proposition that an insured's coverage should only be lost when the insurer has been prejudiced").

insured of a condition of the policy . . . but the breach cannot be a valid defense unless the insurer was substantially prejudiced thereby." *Campbell v. Allstate Ins. Co.*, 384 P.2d 155, 156 (Cal. 1963) (collecting cases). "In order to demonstrate actual, substantial prejudice from lack of timely notice, an insurer must show it lost something that would have changed the handling of the underlying claim." *Shell Oil*, 15 Cal. Rptr. 2d at 846. California's notice-prejudice rule, which predated ERISA by nine years, is grounded in public policy concerns for the protection of policyholders against forfeiture of their insurance benefits:

> If public policy dictates that those injured should be compensated it should not countenance an argument which precludes just compensation in those cases where the injurious consequences of the accident may be long in unfolding.

Hanover Ins. Co. v. Carroll, 50 Cal. Rptr. 704, 712 (Ct. App. 1966).

The many States that follow some variation of the notice-prejudice rule do so "to protect the interests of policyholders because insurance contracts are contracts of adhesion and policyholders should not lose the benefits of coverage unless the delay has prejudiced the insurance company." *Pfizer, Inc. v. Employers Ins. Co. of Wasau*, 712 A.2d 634, 644 (N.J. 1998).[7] These States, like California, override notice-forfeiture provisions that would otherwise be treated as conditions precedent:

> [A]lthough the policy may speak of the notice provision in terms of 'condition precedent,' . . . nonetheless what is involved is a forfeiture, for the carrier seeks, on account of a breach of that provision, to deny the insured the very thing paid for . . . Thus viewed, it becomes unreasonable to read the provision

[7] *See also* Richard L. Suter, *Insurer Prejudice: Analysis of an Expanding Doctrine in Insurance Coverage Law*, 46 Me. L. Rev. 221, 225-28 (1994) (discussing evolution of notice-prejudice as a rule of insurance law in Maine).

> unrealistically or to find that the carrier may forfeit the coverage, even though there is no likelihood that it was prejudiced by the breach. To do so would be unfair to insureds. It would also disserve the public interest, for insurance is an instrument of social policy that the victims of negligence be compensated.

Cooper v. Government Employees Ins. Co., 237 A.2d 870, 873-74 (N.J. 1968).

By contrast, a minority of States have declined to adopt notice-prejudice rules, and instead choose to exercise their authority to regulate the insurer-insured relationship by strictly enforcing notice provisions in insurance contracts.[8] For example, Colorado law provides that "an unexcused delay in giving notice or forwarding suit papers relieves the insurer of its obligations under the policy." *Marez v. Dairyland Ins. Co.*, 638 P.2d 286, 290 (Colo. 1981). *See also Unigard Security Ins. Co. v. North River Ins. Co.*, 594 N.E.2d 571, 573 (N.Y. 1992). But even those States that do enforce such requirements have done so because of policy concerns related to insurance. *See id.*

The similarities between the notice-prejudice rule and the mandated benefits law saved from preemption in *Metropolitan Life* also support the conclusion that the notice-prejudice rule regulates insurance and is saved from preemption. The Court in *Metropolitan Life* concluded that a "common-sense view of the matter" demonstrated that the Massachusetts law mandating mental health benefits for inclusion in ERISA plans "regulates the terms of certain insurance contracts" because it required insurers to provide a certain kind of benefit. 471 U.S. at 740. This reasoning applies with equal force here. Like the mandated benefits law, the notice-prejudice rule regulates the terms of insurance contracts by effectively imposing a

[8] Alabama, Arkansas, Colorado, the District of Columbia, Idaho, Illinois, Louisiana, Mississippi, Nevada, New York, South Dakota, Tennessee, and Virginia permit forfeiture for noncompliance with notice conditions. *See* Anderson, 65 Fordham L. Rev. at 862-68 (collecting cases).

mandatory term on all contracts by preventing insurers from strictly enforcing notice clauses in insurance policies. Accordingly, the notice-prejudice rule meets the "common-sense" test this Court has devised for determining whether a state law regulates insurance.

The notice-prejudice rule is readily distinguishable from the state law that was preempted in *Pilot Life*. There, this Court held that the saving clause did not apply, and held preempted a state common law cause of action against an insurer because "[a]ny breach of contract, and not merely breach of an insurance contract, may lead to liability for punitive damages under Mississippi law." 481 U.S. at 50. Here, by contrast, breach of a notice provision in any contract will not trigger the notice-prejudice rule because the rule only applies to contracts for insurance. The notice-prejudice rule was specifically developed in the insurance context, and courts have recognized that the rule is specifically intended for application to insurance contracts. *See, e.g., Pacific Employers Ins. Co. v. Superior Court,* 270 Cal. Rptr. 779, 783 (Ct. App. 1990) ("California's 'notice-prejudice' . . . rule was developed in the context of 'occurrence' policies"); *Safeco Title Ins. Co. v. Gannon,* 774 P.2d 30, 34 (Wash. Ct. App. 1989) (stating that Washington's notice-prejudice rule "applies to the notice provisions usually found in cooperation clauses, which exclude coverage if the insured fails to notify the insurer of accidents or occurrences in a timely manner").[9]

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[9] Indeed, the notice-prejudice rule is not only directed at the insurance industry, but in some States is directed at a specific kind of insurance policy. Although many States have notice-prejudice rules for "occurrence policies"—policies in which the event insured against is the actual mishap—some state courts have held that notice-prejudice rules do not apply to "claims-made" (*e.g.*, malpractice) policies because applying a notice-prejudice rule in that context would "alter the fundamental terms of the contract." Wherthey, 53 Md. L. Rev. at 953; *see also Pacific Employers Ins. Co.*, 270 Cal. Rptr. at 784 (to apply the notice-prejudice rule to a claims-made policy "would be to convert [the] claims-made policy into an occurrence policy").

Amicus Business Roundtable would distinguish common law rules from statutes and urges the Court to "be especially cautious" before treating common law rules as laws that regulate insurance under ERISA. *See* Business Roundtable Br. *Am. Cur.* 21. This distinction is untenable for three reasons.

First, the decisions of state courts fit squarely within the definition of "State law" in ERISA's preemption section, 29 U.S.C. § 1144, which provides that "[t]he term 'State law' includes all laws, decisions, rules, regulations, or other State action having the effect of law." *Id.* § 1144 (c)(1). Second, the common law decisions of state courts are one of the principal sources of the laws by which States regulate insurance. *See* Robert E. Keeton, *Basic Text on Insurance Law* § 8.1(b), at 542 (1971) ("Insurance transactions and institutions are subject to regulation, in a broad sense, not only at the hands of administrative agencies specially created for this purpose but also at the hands of legislatures and courts."). Third, it would be fundamentally illogical to preempt a common-law notice-prejudice rule while saving notice-prejudice rules set forth in statutes or regulations; all three kinds of rules have the same regulatory effect on the insurance industry.[10] State notice-prejudice rules of each kind are saved from preemption by ERISA's saving clause.

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[10] *Compare* Mass. Gen. L. ch. 175, § 112 ("An insurance company shall not deny insurance coverage to an insured because of failure of an insured to seasonably notify an insurance company of an occurrence, incident, [or] claim . . . which may give rise to liability insured against unless the insurance company has been prejudiced thereby.") *with Brakeman v. Potomac Ins. Co.*, 371 A.2d 193, 196-97 (Pa. 1977) (insured's failure to file notice of loss within the deadline set by policy does not bar coverage unless carrier can prove prejudice as a result; court is "reluctant . . . to allow an insurance company to refuse to provide that which it was paid for unless a sound reason exists for doing so").

B. The *Pireno* Factors Support The Conclusion That The Notice-Prejudice Rule Is A State Law Which Regulates Insurance

Applying the *Pireno* factors to the notice-prejudice rule reinforces the conclusion that the rule "regulates insurance." *Amici* will first address the two factors that the court of appeals found were met by the notice-prejudice rule and then discuss in more detail the first *Pireno* factor, risk-spreading, which it found was absent.

The second *Pireno* factor asks whether the business practice is "an integral part of the policy relationship between the insurer and the insured." *Pilot Life*, 481 U.S. at 48-49 (quoting *Pireno*, 458 U.S. at 129). The notice-prejudice rule is plainly an integral part of this relationship because it regulates the policy relationship between insurers and insureds by preventing insurance companies from strictly enforcing notice deadlines. *See Metropolitan Life*, 471 U.S. at 743 (holding mandated benefits law is an integral part of the insurer-policyholder relationship because it "limit[s] the type of insurance an insurer may sell to the policyholder"). Indeed, the regulation of the insured-insurer relationship by notice-prejudice rules is fully consistent with ERISA's fundamental objective of protecting plan beneficiaries.

UNUM contends, however, that the notice-prejudice rule is not integral to the insurer-insured relationship as required by *Pireno* because the rule "has its trunk and roots in two common-law contract rules of the broadest general application which apply to *all* private parties, including insurance companies." Pet. Br. 27. In support of this assertion, it cites general contract cases and rules related to the materiality of breaches and concludes that these cases also require that prejudice be shown before a party may be excused from performance of a contract. *Id.* at 28.

While it may be true that a finding of prejudice may be required in other contexts before a breach of contract will excuse performance, there is no general principle to

be found that, as a matter of law, notice provisions are unenforceable in the absence of a showing of prejudice. If anything, just the opposite is true. As the many States that have adopted the notice-prejudice rule have recognized, the notice-prejudice rule is a departure from traditional contract principles. Absent the existence of a notice-prejudice rule, traditional contract principles would dictate that notice provisions in insurance contracts be strictly enforced as conditions precedent to performance. *See, e.g., Marez*, 638 P.2d at 290 (strict enforcement of notice provisions is "based on traditional principles of contract law"); *Brakeman*, 371 A.2d at 196 (adopting a notice-prejudice rule because "[a] strict contractual approach is . . . inappropriate"); *Jones v. Bituminous Casualty Corp.*, 821 S.W.2d 798, 801 (Ky. 1991) (adopting notice-prejudice rule and noting that "traditional" view is that the "liability insurer need not show that it was prejudiced by an insured's unreasonable and unexcused omission or delay in giving notice") (citation and internal quotation marks omitted). Commentators also share the view that notice-prejudice rules represent a departure from traditional contract principles. *See, e.g.*, Ostrager & Newman, § 4.02[c][1], at 108-09 (collecting cases adhering to "the traditional approach [which] treats proper notice as a condition precedent to coverage").

This settled view of the notice-prejudice rule as a departure from general contract principles makes sense because, again, this rule applies only in the insurance context. *Amici* cannot find—and UNUM does not cite—a single California case that applies the notice-prejudice rule outside the insurance context. The United States' survey of California law yielded the same result. *See* Br. *Am. Cur.* U.S. 12.

UNUM also contends that the notice-prejudice rule does not satisfy the third *Pireno* factor, which asks whether the law is "limited to entities within the insurance industry." *Pilot Life*, 481 U.S. at 48 (quoting *Pireno*, 458 U.S. at 129). In its view, the notice-prejudice rule is merely " 'identified' with insurance cases." Pet. Br. 30. To sup-

port this assertion, UNUM again relies on its flawed contention that the notice-prejudice rule is a general contract principle. *See id.* And again, the answer to this assertion is that the notice-prejudice rule is identified with and applied exclusively to insurance contracts. This rule, like the mandated benefits law in *Metropolitan Life*, "impose[s] requirements only on insurers." *Metropolitan Life*, 471 U.S. at 743, and accordingly satisfies the third *Pireno* factor.

If this Court agrees with the court of appeals that the notice-prejudice rule clearly satisfies at least two of the three *Pireno* factors, it may conclude that satisfaction of the risk-spreading factor is irrelevant. There is nothing in any of this Court's prior holdings that makes a finding that all three factors are present essential before state law may be saved because it regulates insurance. UNUM, however, insists that the risk-spreading factor is indispensable to an insurance regulation, and turns for support to this Court's decisions construing the second clause of § 2(b) of the McCarran-Ferguson Act, the antitrust immunity clause. *See* Pet. Br. 24 (quoting *Royal Drug*, 440 U.S. at 211-13).

The flaw in UNUM's analysis is that *Royal Drug* did not concern saving state laws, but rather whether business practices between an insurance company and third parties constituted the "business of insurance." *See Royal Drug*, 440 U.S. at 209-10. In *Royal Drug*, this Court held that arrangements for the purchase of goods and services between an insurer and pharmacies did not constitute the "business of insurance" under McCarran-Ferguson's antitrust immunity clause. *See id.* at 217. But *Royal Drug*'s analysis of the indispensable characteristics of the "business of insurance" in the antitrust immunity context does not control the entirely distinct question of whether a state law must regulate the spread of risk in order to qualify as a law regulating insurance under ERISA.

In any event, it is also questionable whether the Ninth Circuit correctly concluded that this factor—that the

practice "has the effect of transferring or spreading a policyholder's risk," *Pilot Life*, 481 U.S. at 48 (quoting *Pireno*, 458 U.S. at 129)—is not met by the notice-prejudice rule. The notice-prejudice rule dictates that individuals should not lose coverage simply because they submit late notices to the insurer. Accordingly, the various risks that insurers guard against by including notice requirements in their policies must be addressed in other ways, possibly including higher insurance premiums to cover the additional costs that the notice-prejudice rule imposes on the insurers. This analysis is fully consistent with the Court's determination in *Metropolitan Life* that the mandated benefits law spread risk because "it was intended to effectuate the legislative judgment that the risk of mental-health care should be shared." *Metropolitan Life*, 471 U.S. at 743. Like ERISA plans in Massachusetts, insurance companies doing business in California and all other States will factor into their premiums the cost of complying with state insurance laws. Hence, *Pireno*'s risk-spreading requirement is satisfied: the notice-prejudice rule spreads risk because it alters the contractual apportionment of risk among the parties.

C. The Notice-Prejudice Rule Does Not Conflict With Any Of ERISA's Substantive Provisions, Including ERISA's Civil Enforcement Scheme

UNUM argues that the notice-prejudice rule is inconsistent with ERISA and its objectives because the rule conflicts with one or more of ERISA's statutory provisions, including its civil enforcement scheme. Pet. Br. 32-36. Properly analyzed in light of the saving clause, and Congress's clear intent to preserve the States' power to regulate insurance, these claims do not withstand analysis.

UNUM cites several provisions of ERISA, such as its fiduciary standards that require fiduciaries to follow the written terms of the plan and to pay benefits according to those terms, in an effort to demonstrate that the notice-prejudice rule would undermine ERISA's objectives. *See*

Pet. Br. 32-36. UNUM's analysis "reads the saving clause out of ERISA entirely." *Metropolitan Life*, 471 U.S. at 741. Under its reasoning, no state or federal law would be saved if it conflicted with the terms of an insurance contract. UNUM's argument turns on its head ERISA's overriding goal of protecting plan participants and their beneficiaries. *See, e.g.*, 29 U.S.C. § 1001(a). The ERISA fiduciary provisions cannot reasonably be read to require that plan terms must be enforced notwithstanding contrary state insurance law that is saved from preemption under ERISA. In other words, illegal contract terms cannot be enforced.

UNUM's other conflicts arguments are equally unavailing. UNUM argues that ERISA authorizes actions for benefits only if they are "due," while the notice-prejudice rule requires payment even if benefits are not due under the contract. Pet. Br. 35. This analysis is flawed because if the notice-prejudice rule is saved, then benefits are due under § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B), despite contractual terms to the contrary. After all, it is unquestionable that only the *enforceable* terms of contracts determine whether beneficiaries are entitled to benefits.

Furthermore, UNUM's claim that the notice-prejudice rule "conflicts with . . . the orderly internal resolution of benefits disputes as a prerequisite to filing suit," Pet. Br. 34, is merely a restatement of its claim that under ERISA it is entitled to literal enforcement of the contract and that state law may not regulate the enforceability of those terms. Again UNUM's contention proves too much because if it is correct, the saving clause would be read out of ERISA completely.

UNUM's argument that the notice-prejudice rule conflicts with ERISA's civil enforcement scheme is also untenable. In *Pilot Life*—a case UNUM argues is controlling here—the plaintiff sued an insurer in a diversity case under a state cause of action that was not covered by the saving clause and that conflicted with ERISA's

civil enforcement scheme. *See* 481 U.S. at 43-44, 57. Here, respondent's suit was brought under federal question jurisdiction in federal court seeking relief only under ERISA § 502(a)(1)(B), 29 U.S.C. § 1132(a)(1)(B). *See* Pet. App. 77a. The notice-prejudice rule does not itself create a cause of action for Mr. Ward; it merely provides a basis under which the notice provision in the contract may not be read to prevent recovery of benefits that would otherwise be due under the terms of the plan. The notice-prejudice rule is therefore properly viewed as a state insurance law that is applied in conjunction with—not in opposition to—ERISA's civil enforcement scheme.

Finally, UNUM predicts a doomsday scenario of "a multiplicity of conflicting federal-state laws on ERISA plan administration" if this Court allows the Ninth Circuit's decision to stand. Pet. Br. 31. Yet UNUM offers no evidence of serious complications stemming from state application of the notice-prejudice rule. If it were correct about the impending dire effects of these rules on ERISA plan management, the consequences would surely have been manifested in at least some of the dozens of States with notice-prejudice rules.

The insurance industry made similar doomsday arguments 15 years ago in *Metropolitan Life*. *See* Brief for Appellant, *Metropolitan Life*, 471 U.S. 724 (1985) (No. 84-325) (arguing that failure to preempt Massachusetts mandated benefits law would "severely hamper the efforts of multistate employers to maintain uniform ERISA plans"). The Court properly rejected this line of argument in that case, and should do so here as well. While UNUM's argument "would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance[, s]uch disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life*, 471 U.S. at 747.

III. THE *ELFSTROM* RULE IS SAVED FROM PREEMPTION

In *Elfstrom v. New York Life Ins. Co.*, 432 P.2d 731 (Cal. 1967), the California Supreme Court announced the rule of insurance law "that the employer is the agent of the insurer in performing the duties of administering group insurance policies." *Id.* at 737. The court of appeals held that the *Elfstrom* rule is not subject to ERISA preemption under § 514(a) because the rule does not "relate to" an employee benefit plan. Pet. App. 20a-24a. Accordingly, the court of appeals had no occasion to address the question whether the *Elfstrom* rule is saved as a rule regulating insurance under § 514(b). If this Court concludes that the *Elfstrom* rule "relate[s] to" ERISA plans under § 514(a), *amici* submit that the *Elfstrom* rule meets the common-sense test for a state law that regulates insurance, satisfies the *Pireno* factors, and does not conflict with ERISA. It is therefore saved from preemption.

A. The *Elfstrom* Rule Meets The Common-Sense Definition Of A Law That Regulates Insurance

The *Elfstrom* rule, which predates ERISA by seven years, was adopted by the California Supreme Court to govern "whether an employer acts as the agent of the insurer or of the employees in administering a policy of group insurance." 432 P.2d at 736. Rejecting the traditional rule making the employer the agent of the employees, the California court joined the courts of several other States in holding that the mistakes of an employer, when acting on behalf of the insurance company, will be imputed to the insurer because the employer is the agent of the insurance company when it administers group plans. *See id.* at 737.

Not all courts have followed the *Elfstrom* approach. *See id.* at 736. The traditional agency rule places the burden of employer mistakes upon the insured, and thus binds

the employees by actions of the employer.[11] This Court, distilling state law, articulated this rule in *Boseman v. Connecticut General Life Ins. Co.*:

> When procuring the policy, obtaining applications of employees, taking pay roll deduction orders, reporting changes in the insured group, paying premiums, and, generally, in doing whatever may serve to obtain and keep the insurance in force, employers act not as agents of the insurer, but for their employees or for themselves.

301 U.S. 196, 204 (1937) (citing cases from six states). The *Elfstrom* rule, by contrast, rejects this approach and places the cost of employer mistakes when administering a plan upon the insurer.[12]

The *Elfstrom* rule is just one part of an insurance regulatory scheme created to protect persons insured under group policies. As Judge Mosk explained in *Elfstrom*, the rule protects beneficiaries from the inequitable outcome of losing benefits due to the mistakes of employers: "[T]he employer carries out the functions which the insurer necessarily would perform in other types of insurance and thereby confers a substantial benefit on the insurer, and . . . since the individual employee has no knowledge of or control over the administrative acts performed by the employer, it would be inequitable to charge him with the employer's errors." 432 P.2d at 737. *See also Norby v. Bankers Life Co.*, 231 N.W.2d 665, 668-69 (Minn. 1975) ("[p]ragmatic, as well as theoretical, considerations" establish that the "conventional" rule is "unreasonable and

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[11] *See* Lee R. Russ & Thomas F. Segalla, *Couch on Insurance* § 8:10 nn. 89-99 and accompanying text (3d ed. 1997) (citing state court decisions rejecting traditional rule); J.A. Appleman & J. Appleman, *Insurance Law and Practice* § 43 (1995 & 1998 Supp.) (citing state cases that make the employer an agent for the insured).

[12] *See Elfstrom*, 432 P.2d at 736-37 (citing six state cases); *Couch On Insurance* § 8:11-8:13 (collecting cases); J.A. Appleman & J. Appleman § 43 (collecting cases).

inequitable"); *Neider v. Continental Assurance Co.*, 35 So.2d 237, 240 (La. 1948) (deeming the employer the agent of the insurer in order to give group insurance "every legitimate opportunity of becoming a social agency of real consequence"). *Cf. Northwestern Nat. Life Ins. Co. v. Riggs*, 203 U.S. 243, 254 (1906) (noting protective purposes of state regulation of life insurance).

The *Elfstrom* rule—"that the employer is the agent of the insurer in performing the duties of administering group insurance policies," 432 P.2d at 737—expressly resolves the designation of agency relationships within the context of group insurance contracts. *See Metropolitan Life Ins. Co. v. State Bd. of Equalization*, 652 P.2d 426, 431 (Cal. 1982) ("*Elfstrom* . . . is controlling on the question of agency. . . . We held as a matter of law that 'the employer is the agent of the insurer in performing the duties of administering group insurance policies.'") (quoting 432 P.2d at 737). Because *Elfstrom* was clearly motivated by a concern unique to group insurance and, like ERISA, directed at protecting beneficiaries, this rule of law is well within this Court's common-sense test for the state laws that Congress intended to save under ERISA.

In 1968, the year after *Elfstrom* was decided, the California legislature enacted a statutory provision that gives parties to group life insurance contracts the ability to modify the *Elfstrom* rule by agreement. California Insurance Code § 10209, found in the Group Life Policies section of the Code, provides that "[t]he contract of insurance and individual certificate may contain provisions defining the extent to which the employer acts as the agent of the employee or may act as the agent of the insurer." The enactment of § 10209 demonstrates that the legislature has addressed the agency question in the group life insurance context and authorized parties to depart from the rule. The existence of § 10209, expressly providing for departures from *Elfstrom* in group life insurance contracts but leaving that rule in place for other

group insurance contracts, reinforces the conclusion that *Elfstrom* is a state law that regulates insurance. *See Elfstrom*, 432 P.2d at 738 n.9 (noting the lack of legislation concerning the agency relationship in group policies as justification for creation of a common-law rule).[13]

California's scheme regulating agency relationships in group insurance contracts is specifically directed at the insurance industry. Therefore, the entirety of the law—part common law and part statutory—is saved under ERISA because together it comprises the state law that determines agency relationships in group insurance.

B. The *Pireno* Factors Support The Conclusion That The *Elfstrom* Rule Is A Law Regulating Insurance

The *Pireno* factors also support the conclusion that the *Elfstrom* rule is a state law that regulates insurance. The first *Pireno* factor, "risk-spreading," presents the closest question, although *Elfstrom* satisfies that factor as well as the other two. As explained above, *see* pp. 5-10, *supra*, a state law need not satisfy all three *Pireno* factors in order to be saved. In any event, the *Elfstrom* rule satisfies all three, including the risk-spreading factor. The rule is similar to the Ohio statute saved in *Fabe*, which protected the insured by ensuring performance of the insurance contract in the event of the company's intervening bankruptcy. *See* 508 U.S. at 503-04. This Court held the statute satisfied the risk-spreading factor of *Pireno* because "actual performance of an insurance contract falls within the 'business of insurance,'" and "[w]ithout performance of the terms of the insurance policy, there is no

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[13] The court of appeals suggested that an insurer's "overt disavowal of the sufficiency of the employer's performance of functions under the plan, actually communicated" to the insured might foreclose reliance on the relationships created as a matter of law by *Elfstrom*. Pet. App. 23a. The court of appeals also highlighted *Elfstrom's* status as a special rule of law by recognizing that under common law principles of agency, the facts, and not the understanding of the parties, define the agency relationship. *Id.* at 14a-15a.

risk transfer at all." *Id.* *Elfstrom* likewise affects the transfer of risk by requiring performance of the insurance contract despite the occurrence of events that might otherwise relieve the insurer of that responsibility.

The second and third *Pireno* factors are also satisfied because, by treating the employer as the agent of the insurer, the *Elfstrom* rule dictates the terms of the insurance relationship, thus becoming " 'an integral part of the policy relationship between the insurer and the insured.' " *Metropolitan Life*, 471 U.S. at 743 (quoting 458 U.S. at 129). The third *Pireno* factor looks to whether a law " 'is limited to entities within the insurance industry.' " [14] *Metropolitan Life*, 471 U.S. at 743 (quoting 458 U.S. at 129). The *Elfstrom* rule and § 10209 of the California Insurance Code apply and, by their express terms, relate exclusively to the relationship between employers and insurers with the required "intent of affecting the relationship between the insurer and the policyholder." *Metropolitan Life*, 471 U.S. at 743. Thus, application of *Pireno* supports the common-sense conclusion that California's group insurance agency rule is saved.

C. The *Elfstrom* Rule Is Consistent With ERISA's Fiduciary Provisions

The *Elfstrom* rule cannot be saved if it is inconsistent with "the role of the saving clause in ERISA as a whole." *See Pilot Life*, 481 U.S. at 51. In this regard, UNUM argues that the *Elfstrom* rule "directly conflicts with [ERISA's] specific fiduciary and co-fiduciary responsibility rules." [15] Pet. Br. 43. Similarly, the United States

[14] Some state courts even draw upon the authority of state statutes defining insurance agents to liken the employer to an ordinary insurance agent when performing administrative tasks. *See, e.g., Cason v. Aetna Life Ins. Co.*, 85 S.E.2d 568, 573 (Ga. Ct. App. 1954) (citing Georgia's statute defining "insurance agents," formerly § 56-501, now § 33-23-1).

[15] In order to further buttress its argument that the *Elfstrom* rule is in conflict with ERISA, UNUM argues that *Elfstrom* conflicts with the civil enforcement provisions of ERISA. Pet. Br. 45.

asserts, without explanation, that the *Elfstrom* rule "forces the employer, as plan administrator, to assume a role, with attendant legal duties and consequences, that it has not undertaken voluntarily." Br. *Am. Cur.* U.S. 27. These contentions are erroneous. The *Elfstrom* rule creates no duties or obligations. Rather, as the court of appeals noted, *see* Pet. App. 22a, it describes the legal consequences of administrative duties undertaken voluntarily by employers.

Furthermore, ERISA's fiduciary provisions do not conflict with *Elfstrom*. An employer has a fiduciary duty only "to the extent" of particular discretionary fiduciary functions that he or she elects to perform, 29 U.S.C. § 1002(21)(A), and the hallmark of all fiduciary functions is discretion. Fiduciary functions include asset management, discretionary administrative functions and investment advice. Whether a fiduciary is "named" under § 402(a), 29 U.S.C. § 1102(a), or is considered one under 29 U.S.C. § 1002(21)(a), ERISA creates obligations for the employer only when an employer acts as a fiduciary, *i.e.* when exercising discretionary authority or control over plan management. *See* 29 C.F.R. § 2509.75-8. Thus, when an insured alleges a breach of fiduciary duty,[16] the court must begin by asking "whether a person is a fiduciary with respect to the particular activity at issue," for a fiduciary for some purposes is not a fiduciary for all

Like the notice-prejudice rule, however, the *Elfstrom* rule does not create a remedy. Instead, it works within the enforcement scheme created by Congress.

[16] A fiduciary owes several duties to the beneficiaries. First, the fiduciary must act "solely in the interest of the participants and beneficiaries." 29 U.S.C. § 1104(a)(1). Ordinarily, a breach of this duty involves a material misrepresentation to beneficiaries. Second, the fiduciary must act with "prudence," *id.* § 1104(a)(1)(B), which has been applied almost exclusively to the management of funds. Third, the fiduciary has an obligation of "diversifying the investments" for the benefit of the plan. *Id.* § 1104(a)(1)(C). Finally, a fiduciary must act in accordance with the plan. *Id.* § 1104(a)(1)(D).

purposes. *Coleman v. Nationwide Life Ins. Co.*, 969 F.2d 54, 61 (4th Cir. 1992), *cert. denied*, 506 U.S. 1081 (1993).

The types of actions that create an agency relationship, such as exists under *Elfstrom*, are not parallel to fiduciary obligations. Factors that traditionally create an employer-insurer agency relationship include determining eligibility, forwarding premiums and reinstating employees. *See Couch on Insurance* § 8:11. These are not actions that would create a fiduciary duty because they are ministerial and administrative, not discretionary. *See* Interpretive Bulletins Relating to ERISA, 29 C.F.R. § 2509.75-8 (DOL statement that "a person who performs purely ministerial functions such as [collection of contributions] for an employee benefit plan within a framework of policies, interpretations, rules, practices and procedures made by other persons is not a fiduciary because such person does not have discretionary authority"). Furthermore, the *Elfstrom* analysis, like fiduciary analysis, is restricted to the activities actually undertaken by the employer to determine an agency relationship. *See, e.g., Baum v. Massachusetts Mutual Life Ins. Co.*, 357 P.2d 960, 964 (Okla. 1960) ("In performing these functions employer acted as the agent of insurer, and since it so acted, insurer is charged with knowledge possessed by employer while so acting.").

Moreover, the insurer, concerned that *Elfstrom* might be implicated by the actions of an employer fiduciary, may take steps to avoid the consequences imposed by *Elfstrom*. Section 10209 of the California Insurance Code potentially gives the insurer the ability to define the agency relationship in at least some plans although, as the court of appeals recognized, a "hidden disclaimer" alone cannot negate the agency relationship because "the participants . . . should be able to rely upon the relationships that exist." Pet. App. 23a.

Finally, ERISA is silent with respect to the insurance agency relationship. "A reading of [the preemption

clause] resulting in the pre-emption of traditionally state-regulated substantive law in those areas where ERISA has nothing to say would be 'unsettling.' " *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 330 (1997) (quoting *Travelers*, 514 U.S. at 665). ERISA does not address which individuals may be designated an agent of the group insurer; a state law with respect to such an issue is plainly consistent with ERISA's objective of protecting beneficiaries. The United States appears to agree that the *Elfstrom* rule would not conflict with the fiduciary provisions of ERISA because it suggests that this rule could be adopted as a matter of federal common law. *See* Br. *Am. Cur.* U.S. 28. However, the determination of whether and when an employer is the agent of a group insurer is best left to state law, as it is an issue that falls squarely within the regulation of insurance, a responsibility of the States for 150 years.

CONCLUSION

The judgment of the court of appeals should be affirmed.

Respectfully submitted,

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Supreme Court of the United States

October Term, 1998

UNUM LIFE INSURANCE COMPANY OF AMERICA,

Petitioner,

v.

JOHN E. WARD,

Respondent.

On Writ Of Certiorari To The United States Court Of Appeals For The Ninth Circuit

BRIEF OF THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS AMICUS CURIAE SUPPORTING RESPONDENT

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QUESTION PRESENTED

Whether the California notice-prejudice rule, which requires an insurer to demonstrate prejudice before it can deny a claim for benefits as untimely, is "saved" from preemption under Section 514(a) of the Employee Retirement Income Security Act of 1974 ("ERISA"), 29 U.S.C. § 1144(a), because it is a state law which "regulates insurance" under ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A).

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INTEREST OF *AMICUS CURIAE*[1]

The National Association of Insurance Commissioners ("NAIC") is a non-profit legal association whose members are the chief insurance regulators in each state, territory and the District of Columbia. The NAIC's purpose is to serve the public by assisting these regulatory officials in the pursuit of fundamental insurance regulatory objectives, including:

(1) Maintaining and improving State regulation of insurance in a responsive and efficient manner;

(2) Maintaining the reliability of insurance business with respect to financial solidity and guarantees against loss; and

(3) Ensuring the fair, just and equitable treatment of policyholders and claimants.

The issues in this case directly implicate the NAIC's objectives by addressing the scope of the provision in the Employee Retirement Income Security Act of 1974 ("ERISA") that saves state laws that regulate insurance from ERISA preemption. The "saving clause" was enacted to preserve the states' traditional regulation of insurance. The NAIC and its members have an ongoing

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[1] Pursuant to Rule 37.6 of the Rules of this Court, counsel for *amicus curiae* states that neither counsel for Petitioner nor for Respondent authored this brief, in whole or in part, and no person or entity other than this amicus made a monetary contribution to the preparation or submission of this brief.

Pursuant to Rule 37.3 of the Rules of this Court, the parties have consented to the filing of this brief *amicus curiae*. Their letters of consent have been filed with the Clerk of the Court.

interest in ensuring that the saving clause is interpreted and applied properly. In particular, the NAIC has an interest in ensuring that state laws, including the California notice-prejudice rule at issue in this case, protect insurance claimants such as Respondent from being denied benefits in contravention of applicable state insurance law.

STATEMENT OF THE CASE

Amicus incorporates by reference the Statements of the Case submitted by Respondent and the United States as *Amicus Curiae*.

SUMMARY OF ARGUMENT

This case presents the Court with an opportunity to reaffirm the broad extent to which state insurance laws and regulations are saved from ERISA preemption and to ensure that ERISA preemption is not used as a defensive tool to negate substantive state law protections afforded participants and beneficiaries under insured ERISA plans. At issue is California's "notice-prejudice rule," which precludes arbitrary time-barring of claims by requiring an insurer to show that it has been prejudiced before it can deny a claim for benefits under an insurance

policy based on the claimant's failure to provide notice within the time limit set forth in the policy.[2]

Petitioner contends that the notice-prejudice rule is preempted by ERISA. 29 U.S.C. § 1144(a). To the contrary, ERISA does not bar application of the notice-prejudice rule to insurance policies purchased by ERISA plans because the rule fits squarely within ERISA's so-called "saving clause." 29 U.S.C. § 1144(b)(2)(A). The saving clause excepts from ERISA preemption every state law which "regulates insurance," with one narrow exception not relevant to this case. *See id.*

In determining whether a state statute, regulation, or common law regulates insurance within the meaning of ERISA, this Court applies a "common sense" test. *See Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 740 (1985). As a matter of common sense, the notice-prejudice rule regulates insurance: the requirements for submitting a claim are central to the insurance relationship and go directly to whether the insurer will bear the risk of loss it promised to assume.

Petitioner contends that the saving clause does not prevent preemption of the notice-prejudice rule because that rule fails to satisfy the three-factors designed as "guideposts" for interpreting the "reverse preemption" clause of the McCarran-Ferguson Act, 15 U.S.C. § 1012(b). This Court has not required that these factors be rigidly

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[2] "[A]t least twenty-five states currently follow some variation of the notice-prejudice rule, demonstrating its widespread acceptance." *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d 939, 945 (9th Cir. 1998) (citation omitted), *petition for cert. filed*, 66 U.S.L.W. 3773 (U.S. May 20, 1998) (No. 97-1867).

applied in ERISA saving clause analysis. Indeed, if the three factors were rigidly applied, basic state laws which regulate insurance as a matter of common sense would be in jeopardy of preemption. Such a result would be contrary to preserving the traditional system of state insurance regulation which Congress intended in enacting the saving clause.

Further, ERISA's saving clause is broader than the McCarran-Ferguson Act's narrow exemption for the business of insurance from federal antitrust laws. For these reasons, strict application of the McCarran-Ferguson factors does not and should not control saving clause analyses.

Petitioner's argument that the notice-prejudice rule is preempted because it conflicts with ERISA's substantive provisions is equally unavailing. The plain language of Section 514(a) makes clear that state laws which regulate insurance, whether procedural or substantive, are exempt from the reach of ERISA's preemptive language.

Moreover, nothing in the language of ERISA or in the Court's decision in *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41 (1987), supports the theory that every state law which is remedial in nature is preempted. Many state laws central to sound insurance regulations, including laws providing a state insurance commissioner authority to discipline insurers which fail to maintain an adequate net worth, engage in a pattern of unlawful discriminatory treatment towards a group of policyholders, or fail to control misleading representations made by agents, remain in force regardless of whether such matters impact insured ERISA plans.

Even if Petitioner's conflict preemption approach applied in this case, the notice-prejudice rule does not conflict with ERISA. Respondent has asserted a claim for benefits under ERISA, and the notice-prejudice rule is simply a procedural rule which is relevant to determining the validity of that claim. The notice-prejudice rule is also consistent with ERISA's goal of maximizing benefits for participants and beneficiaries. Therefore, the notice-prejudice rule is not preempted by notions of conflict preemption.

Finally, the emphasis which Petitioner and its supporting amici place on notions of uniform federal regulation of employee benefit plans is misplaced. Congress and the courts have recognized and appreciate the fact that the enactment of ERISA created a "disuniformity" between self-insured plans, which are primarily subject to federal regulation, and insured plans, which are subject to federal regulation and indirectly to state insurance regulations. *See, e.g., Metropolitan Life*, 471 U.S. at 747. That dichotomy is the natural and inevitable result of Congress's decision to preserve state regulation of insurance.

Petitioner's obligation to ensure that the terms and conditions of its group policies comply with all applicable state laws is no different than its obligation with respect to its individual disability policies offered across the country. Regardless of whether a policy provides benefits to one beneficiary under an individual policy or 1,000 beneficiaries under a group policy, state insurance regulations apply.

As the federal and state governments (the United States, the National Association of Attorneys General, and the NAIC) have demonstrated in their amicus briefs, the enactment of ERISA in 1974 did not extinguish application of state insurance laws and regulations to licensed insurers furnishing insurance benefits to ERISA plans. Petitioner's attempt to narrow the effectiveness of the saving clause should be defeated by affirming the decision of the Ninth Circuit.

ARGUMENT

I. THE NINTH CIRCUIT CORRECTLY HELD THAT THE NOTICE-PREJUDICE RULE IS SAVED FROM ERISA PREEMPTION BY THE INSURANCE SAVING CLAUSE.

A. The Insurance Saving Clause Provides A Broad Exception To ERISA's Preemption Of State Laws.

Petitioner suggests that the saving clause should be read narrowly. However, this Court has recognized: "While § 514(a) of ERISA broadly pre-empts state laws that relate to an employee-benefit plan, that preemption is substantially qualified by an 'insurance-saving clause,' which broadly states that, with one exception, nothing in ERISA 'shall be construed to exempt or relieve any person from any law of any State which regulates insurance, banking or securities.' "[3] *Metropolitan Life*, 471 U.S. at 733

[3] The so-called "deemer clause" exception to the saving clause is not applicable here. The deemer clause provides that a state law that purports to regulate insurance by "deeming" a plan to be an insurance company is not saved from ERISA preemption. 29 U.S.C. § 1144(b)(2)(B). Petitioner contends that the deemer clause bars the application of the notice-prejudice rule to Petitioner as the entity reviewing a denied claim. *See* Petitioner's Brief at 37. However, the deemer clause is directed at ensuring that self-insured plans remain outside the scope of state insurance regulation. *See Metropolitan Life*, 471 U.S. at 747. Because this case does not involve a self-insured plan, Petitioner's argument that the deemer clause bars the application of the notice-prejudice rule as to Petitioner is misplaced.

(citation omitted). "[W]hile the general preemption clause broadly pre-empts state law, the saving clause appears broadly to preserve the States' lawmaking power over much of the same regulation." *Id.* at 739-40.

Given the plain language and meaning of the statute, this Court has stated that it "also must presume that Congress did not intend to pre-empt areas of traditional state regulation." *Id.* at 740. *See also FMC Corp. v. Holliday*, 498 U.S. 52, 63 (1990) ("[W]e observe Congress' presumed desire to reserve to the States the regulation of the 'business of insurance.' "). The business of insurance has traditionally been regulated by the states. The very purpose of the saving clause as applied to the regulation of insurance was and is to preserve state regulation of insurance policies purchased by ERISA plans.

The Supreme Court has rejected the notion that the saving clause should be interpreted narrowly as Petitioner suggests in this case:

> If a state law "regulates insurance," . . . it is not preempted. Nothing in the language, structure,

> or legislative history of the Act supports a more narrow reading of the clause, whether it be the [Massachusetts] Supreme Judicial Court's attempt to save only state regulations unrelated to the substantive provisions of ERISA, or the insurers' more speculative attempt to read the saving clause out of the statute.

Metropolitan Life, 471 U.S. at 746-47.

Maintaining the viability of the saving clause is also consistent with ERISA's goal of protecting benefits available under ERISA plans. *See, e.g.*, 29 U.S.C. § 1001 (setting out congressional policy regarding ERISA); S. Rep. No. 93-127, 93rd Cong., 1st Sess. 18 (1973) (coverage is to be construed liberally to provide the maximum degree of protection to participants); *Firestone Tire & Rubber Co. v. Bruch*, 489 U.S. 101, 113 (1989) ("ERISA was enacted to promote the interests of employees and their beneficiaries in employee benefit plans.") (Quotation omitted).

Through ERISA and the insurance saving clause, ERISA plan participants and beneficiaries and employers who sponsor ERISA plans thus enjoy the protections afforded by ERISA and, if covered by insured plans, the protections afforded by state insurance laws and regulations, as well. The fact that many employers elect to purchase insured products to provide coverage for their employees reflects the advantages that such plans offer when compared with self-funded plans.

For example, insured plans have solvency protections afforded by state insurance regulation and access to guaranty association coverage. Employers thus can avoid or limit the risk of plan failure, as well as the possibility that they would have to fund any shortfall. Although there

may be trade-offs that accompany these protections, the federal and state regulatory systems are most effective with a broad interpretation and application of the saving clause.

B. As A Matter Of Common Sense, The Notice-Prejudice Rule "Regulates Insurance" And Is Therefore Saved From ERISA Preemption Under The Saving Clause.

This Court has effectuated Congress' intent regarding the saving clause by instructing that state laws which regulate insurance as a matter of "common sense" are saved from ERISA preemption. *Metropolitan Life*, 471 U.S. at 740. *See also Pilot Life*, 481 U.S. at 48. This Court has explained that "[w]e have identified laws governing the 'business of insurance' in the Act to include not only direct regulation of the insurer but also regulation of the substantive terms of insurance contracts." *FMC Corp. v. Holliday*, 498 U.S. at 62 (citing *Metropolitan Life*, 471 U.S. at 742-44). Such laws include those governing the sale and advertisement of insurance and laws specifying the content of insurance contracts. *Metropolitan Life*, 471 U.S. at 727-28. *See also id.* at 728 n.2. Clearly, the notice-prejudice rule is directed to the substance of Petitioner's insurance policy and thus "regulates insurance."

In *Metropolitan Life*, this Court addressed whether ERISA preempted a Massachusetts law which mandated that minimum mental health care benefits be provided to Massachusetts residents insured under a general insurance policy, an accident or sickness insurance policy, or an employee health care plan that covered hospital and

surgical expenses. 471 U.S. at 727. The insurance companies argued that the law was not saved from preemption because it was a health law, not a traditional insurance law. *Id.* at 741. Rejecting the insurers' position, the Court found that as a matter of common sense, the State law regulated the terms of certain insurance contracts and was protected from preemption by the saving clause. *Id.* at 740-41.

More recently, this Court explained that while the deemer clause preempted a state anti-subrogation law as to self-insured plans, the saving clause would have saved the law from preemption for insurance contracts purchased by ERISA plans because the law "directly control[led] the terms of insurance contracts by invalidating any subrogation provisions that they contain." *FMC Corp. v. Holliday*, 486 U.S. at 61. The Court plainly stated: "[the law] does not merely have an impact on the insurance industry; it is aimed at it." *Id.* (Citing *Pilot Life*, 481 U.S. at 50). "Unless the [state subrogation] statute is excluded from the reach of the saving clause by virtue of the deemer clause, . . . it is not pre-empted." *Id.*

In this case, Petitioner's incorrect, narrow interpretation of the notice-prejudice rule and the saving clause defies common sense. Like the state anti-subrogation law in *FMC Corp. v. Holliday*, the notice-prejudice rule "directly controls the terms of insurance contracts" by invalidating a policy's time limit for applying for benefits unless the insurer can show that it was prejudiced by the claimant's delay. *See* 498 U.S. at 61. The rule affects the primary issue in any insurance dispute: whether the insured or the insurer will bear the risk of loss which the insurer promised to assume when it issued the insurance

policy. Simply put, granting or denying a claim for benefits under an insurance policy *is* the business of insurance.

Petitioner and its supporting amici contend that the notice-prejudice rule does not regulate insurance as a matter of common sense because the rule is not specifically directed at the insurance industry. Their argument fails for two reasons. First, on its face, the rule regulates insurance. *See Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th 715, 760 (1993) ("California law is settled that a defense based on an insured's failure to give timely notice requires the insurer to prove that it suffered substantial prejudice."). As the United States Court of Appeals for the District of Columbia Circuit recently asked: "[i]f California's [notice-prejudice] rule does not regulate insurance, what does it regulate?" *O'Connor v. UNUM Life Ins. Co.*, 146 F.3d 959, 963 (D.C. Cir. 1998) (holding that the notice-prejudice rule is not preempted by ERISA) (quoting *Cisneros v. UNUM Life Ins. Co.*, 134 F.3d at 946).

Second, any common law of a specific industry may bear a relation to ancient tenets at English common law. Tracing a common law of insurance or any other industry back to its roots in this way could inevitably lead to the conclusion that it was preempted because it is not directed at that industry. This exercise is flawed because the saving clause makes no distinction between state common law and statutory law. *See* 29 U.S.C. § 1144(c)(1) (defining "State law" to include "all laws, decisions, rules, regulations, or other State action having the effect of law, of any State.").

The Ninth Circuit's holding that the notice-prejudice rule regulates insurance and is therefore saved from preemption should be affirmed under the "common sense" test.

C. Petitioner's Rigid Application Of The Three McCarran-Ferguson Act Factors Is Erroneous.

On its face, the notice-prejudice rule is directed at the insurance industry. Nevertheless, Petitioner insists that the rule does not regulate insurance because it does not satisfy a technical checklist based on three factors originally developed by this Court for interpreting the "reverse preemption" clause of the McCarran-Ferguson Act. *See* Petitioner's Brief at 22-23. *See also Union Labor Life Ins. Co. v. Pireno*, 458 U.S. 119, 129 (1982) (identifying the three criteria "relevant in determining whether a particular practice is part of the 'business of insurance' exempted from the antitrust laws by § 2(b)").[4] Petitioner's argument, and the lower court decisions on which Petitioner relies, seriously misconstrue the purpose and meaning of this Court's three-factor McCarran-Ferguson analysis.

The three factors are "simply relevant considerations or guideposts" for clarifying the common sense meaning of insurance regulation, not a reason for negating it. *See Cisneros*, 134 F.3d at 946. *See also FMC Corp. v. Holliday*,

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[4] The three factors are whether the law spreads risk, is an integral part of the relationship between the insurer and the insured, and is directed to entities within the insurance industry. *Pireno*, 458 U.S. at 129.

498 U.S. at 61 (Court recognized that state subrogation law regulated insurance without considering the McCarran-Ferguson factors); *Metropolitan Life*, 471 U.S. at 743 (noting that the three factors are "relevant"). The Fifth Circuit thus mistakenly held to the contrary in *CIGNA Health Plan of Louisiana, Inc. v. State ex rel. Ieyoub*, 82 F.2d 642, 650 (5th Cir.), *cert. denied*, 117 S. Ct. 387 (1996). Indeed, this Court expressly held in *Pireno*, a case interpreting the "business of insurance" under the McCarran-Ferguson Act, that "[n]one of these criteria is necessarily determinative in itself." 458 U.S. at 129.

The Ninth Circuit thus correctly found that the three factors, while relevant, were not to be applied rigidly. *See Cisneros v. UNUM Life Ins. Co.*, 134 F.3d at 946. *See also Ward v. Management Analysis Co. Employee Disability Ben. Plan*, 135 F.3d 1276, 1280 (9th Cir. 1998), *cert. granted*, 67 U.S.L.W. 3257 (U.S. Oct. 13, 1998) (No. 97-1868). Accordingly, the Ninth Circuit found the notice-prejudice rule was not preempted even though it held that the rule did not meet all three factors. *Cisneros*, 134 F.3d at 945-46. The Ninth Circuit elaborated:

> We find unconvincing the idea that Congress and ERISA would save and thereby enforce a state law mandating insurance companies to provide specified coverage whether purchased by the insured or not, yet pre-empt and thereby nullify a state law requiring an insurer to show actual prejudice from late notice before it refuses to pay benefits purchased by the insured.

Id. at 946-47.

Indeed, if the three factors were rigidly applied as Petitioner argues, laws which satisfy the basic common sense meaning of the term "regulate insurance" could be endangered for failure to meet strictly each and every one of the three factors. For example, HMOs have argued that they are not properly subject to state insurance laws because they do not spread risk, but rather provide medical services through access to a medical network, with that network purportedly bearing the risk of loss. However, common sense mandates that HMOs are in the business of insurance:

> In the end, HMOs function the same way as a traditional health insurer: The policyholder pays a fee for a promise of medical services in the event that he should need them. It follows that HMOs (and HCSCs) are in the business of insurance.

Washington Physicians Serv. Ass'n v. Gregoire, 147 F.3d 1039, 1046 (9th Cir. 1998), *petition for cert. filed*, 67 U.S.L.W. 3376 (U.S. Nov. 23, 1998) (No. 98-889). *See also* 29 U.S.C. § 1193(b)(2) (1996) (in enacting the Health Insurance Portability and Accountability Act in 1996, Congress amended ERISA's definition of "health insurance issuer" to include HMOs, specifically recognizing that HMOs may be "subject to State law which regulates insurance (within the meaning of [ERISA] § 514(b)(2))." Accordingly, state insurance laws which regulate HMOs are properly saved from preemption.

Moreover, in enacting ERISA, Congress expressly preserved the basic system of state regulation of insurance, with the state insurance commissioners as the primary regulators. That basic regulatory process remains in force.

The five volume set of NAIC MODEL LAWS, REGULATIONS, AND GUIDELINES (NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS 1998) ("MODEL LAWS") reveals the vast area occupied by state insurance regulation. The annotations to the MODEL LAWS list thousands of state statutes which address such varied topics as insurance company management, investments, accounting requirements, minimum risk based capital, reserve standards, examinations, prohibited insider transactions, insolvency and rehabilitation standards, guaranty funds, agent and broker licensing, contract forms, rating laws, unfair discrimination against policyholders, and improper termination of coverage.

Application of state regulatory powers to insurers, agents, and other licensees engaged in the business of insurance remains the primary function of state regulators. Use of the state administrative law process is central to that function, whereby remedial statutes imposing fines, license suspension or revocation, and requirements of corrective action are applied frequently and routinely. The existence and possible application of those statutes assure a stable and well-functioning insurance market.

Neither the language of ERISA nor the *Pilot Life* decision supports any erosion of state law regulatory powers. To the contrary, the saving clause clearly supports the viability of state insurance regulations.

Further, ERISA's saving clause has been construed more broadly than the corresponding language of the McCarran-Ferguson Act's antitrust exemptions, which is unique in providing reverse preemption of a substantial body of federal law by state law. *Compare* 15 U.S.C.

§ 1012(b) and 29 U.S.C. § 1144(b). The purpose of the second clause of § 1012(b) "was to carve out only a narrow exemption for 'the business of insurance' from the federal antitrust laws." *United States Department of Treasury v. Fabe*, 508 U.S. 491, 505 (1993). By contrast, the saving clause under ERISA has broad application. *See Metropolitan Life*, 471 U.S. at 733. Therefore, strict application of the three McCarran-Ferguson factors does not and should not control in ERISA saving clause analyses. *See O'Connor v. UNUM*, 146 F.3d at 963.

Finally, even though all three factors need not be met for purposes of ERISA's saving clause, the notice-prejudice rule does in fact possess all three McCarran-Ferguson attributes. The notice-prejudice rule addresses the first McCarran-Ferguson factor of spreading risk because Petitioner's stringent procedures for filing a claim for benefits are an attempt by an insurer to negate the risk transfer they promise to assume. The notice-prejudice rule determines whether the claim filing deadline in the insurance contract will be enforced.

The second factor is satisfied because the notice-prejudice rule "directly regulates the relationship between the insurer and the insured." *O'Connor v. UNUM*, 146 F.3d at 963. *See also SEC v. Nat'l Securities, Inc.*, 393 U.S. 453, 460 (1969) (recognizing the second factor as the "focus" of the term "business of insurance.")

The third factor is satisfied because the notice-prejudice rule applies only to the insurance industry. *See O'Connor v. UNUM*, 146 F.3d at 963. *See also Cisneros v. UNUM*, 134 F.3d at 946. Indeed, the rule is expressly stated in terms of prejudice to an "insurer" resulting from

untimely notice. *See Shell Oil Co. v. Winterthur Swiss Ins. Co.*, 12 Cal. App. 4th at 760.

For these reasons, as well, the notice-prejudice rule "regulates insurance" and is thus saved from ERISA preemption.[5]

II. THE NOTICE-PREJUDICE RULE IS NOT PREEMPTED BY AN ALLEGED CONFLICT WITH THE SUBSTANTIVE PROVISIONS OF ERISA.

A. The ERISA Saving Clause Preserves From Preemption All State Laws Regulating Insurance.

The saving clause does not distinguish between state insurance laws that conflict with ERISA and those that do not. Rather, it saves from ERISA preemption all state laws that regulate insurance. In enacting ERISA, Congress did not intend to sweep aside state laws and remedies that regulate insurance. *See* Brief of the United States as Amicus Curiae at 28. "[T]he insurance savings clause, on its face, saves state law conferring causes of action or affecting remedies that regulate insurance, just as it does state mandated-benefits laws and other prescriptive measures that do so." *Id.* at 29-30.

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[5] Even if the Court were to determine that the notice-prejudice rule is not saved from preemption and that the *Elfstrom* rule addressed by the parties and other amici relates to an ERISA plan, the Court should nonetheless uphold the Ninth Circuit's decision in favor of Respondent. To the extent the *Elfstrom* rule directly governs the relationship between and among the insurer, the employer in its capacity as group policyholder and the insured certificateholders, then it clearly regulates insurance and would be saved from preemption.

This Court has explained this point in addressing the removal to federal court of a case in which the State of California Franchise Tax Board sought to enforce a tax levy against money held in a self-funded ERISA vacation trust fund:

> Section 502(a) specifies which persons – participants, beneficiaries, fiduciaries or the Secretary of Labor – may bring actions for particular kinds of relief. It neither creates nor expressly denies any cause of action in favor of state governments, to enforce tax levies or for any other purpose. It does not purport to reach every question relating to plans covered by ERISA. Furthermore, § 514(b)(2)(A) of ERISA, 29 U.S.C. § 1144(b)(2)(A), makes clear that Congress did not intend to preempt entirely every state cause of action relating to such plans. With important, but express limitations, it states that "nothing in this subchapter shall be construed to relieve any person from any law of any State which regulates insurance, banking, or securities."

Franchise Tax Board v. Construction Laborers Vacation Trust, 463 U.S. 1, 25 (1983) (footnote omitted). Although the State in *Franchise Tax* was not seeking to enforce a state insurance regulation, this Court recognized the breadth of the saving clause and the importance of allowing state regulatory bodies to enforce their laws and regulations.

States clearly have the obligation and the right to protect the interests of their citizens with regard to insurance benefits through the enforcement of state insurance laws and regulations. Protection of these enforcement mechanisms is fundamental to the regulatory fabric in which ERISA was enacted. Both the federal and state

governments which have filed amicus briefs in this case agree that ERISA § 502 does not and cannot foreclose access to state-created insurance regulations or sanctions which enforce substantive state insurance laws. 29 U.S.C. § 1132. Congress saved both state substantive insurance law and those measures necessary to enforce state substantive insurance law when it enacted the saving clause. *See* Brief of United States as Amicus Brief at 29 n.12.

The issue in this case differs fundamentally from *Pilot Life*. In that case, this Court recognized that Mississippi's common law of bad faith was not saved from preemption because it did not regulate insurance as a matter of common sense, instead being a law of general application. *Pilot Life*, 481 U.S. at 50.

By contrast, the notice-prejudice rule regulates insurance as a matter of common sense. It follows that the notice-prejudice rule does not and cannot conflict with ERISA's enforcement mechanisms or its fiduciary provisions because ERISA regulates employee benefit plans, not insurance. Therefore, conflict preemption does not serve as a proper basis for analyzing laws, including the notice-prejudice rule, that are saved from preemption by the express language of the saving clause.

B. The Notice-Prejudice Rule Does Not Conflict With The Substantive Provisions Of ERISA.

Even if conflict preemption were a proper basis for analyzing whether a state insurance law is saved from preemption, the notice-prejudice rule is nevertheless saved. That rule does not conflict with ERISA's civil enforcement provisions or ERISA's fiduciary standards,

including the requirement that an employee benefit plan be administered in accordance with its written terms.[6] Petitioner cannot avoid the application of a state law that is otherwise saved from preemption merely because the state law is not incorporated into the terms of Petitioner's policy.

The United States Court of Appeals for the Eighth Circuit rejected such an argument in *United of Omaha v. Business Men's Assur. Co.*, 104 F.3d 1034, 1041 (8th Cir. 1997). In that case, the Court addressed whether ERISA preempted a Missouri statute requiring group health

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[6] The meaning of a "conflict" between ERISA and state law has been addressed with respect to Section 514(b)(6)(A)(ii) of ERISA, 29 U.S.C. § 1144(b)(6)(A)(ii), which excludes MEWAs that are not fully insured from the protection of the deemer clause even if they qualify as ERISA employee benefit plans. Notwithstanding the deemer clause, state insurance laws may be applied directly to such plans to the extent they are "not inconsistent with" ERISA. 29 U.S.C. § 1144(b)(6)(A)(ii). Before invalidating a state law on this basis, courts require that the alleged inconsistency "directly conflict" with ERISA, meaning that compliance with the state law would violate ERISA or its congressional intent. *See, e.g., Fuller v. Olson*, 907 F. Supp. 257, 261 (W.D. Mich. 1995) (finding that Michigan statute requiring MEWA to obtain certificate of authority not preempted). Significantly, the Court in *Fuller* elaborated: "where Congress has expressly permitted states to regulate MEWAs to an extent not inconsistent with ERISA, it is not enough to argue that burdens imposed by state regulation but not imposed by ERISA are 'inconsistent' and therefore preempted." *Id.* Applying the same reasoning, the notice-prejudice rule is properly saved from preemption under § 514(b)(2)(A) because ERISA is silent on the time for making a claim, and the notice-prejudice rule is otherwise consistent with ERISA's purpose of protecting participants' benefits.

insurance policies to provide an extension of benefits for totally disabled beneficiaries upon the plan's termination or discontinuation. *Id.* at 1037. The Court held that the Missouri statute was saved from ERISA preemption. *Id.* at 1041.

In so holding, the Eighth Circuit recognized that the Missouri statute negated a provision in the insurance policy at issue which provided that benefits would only be extended until the recipient obtained other coverage. *Id.* Having found the statute to be saved from preemption, the Court refused to permit a conflicting provision in defendant's plan to override the statute. *Id.* "To do so would be to open the door for insurance companies to avoid any state insurance law simply by including a contrary provision in their group ERISA welfare plans." *Id.*

Similarly in this case, Petitioner cannot avoid an otherwise applicable state law by pointing to contrary provisions in its policy. To hold otherwise would effectively "read[ ] the saving clause out of [ERISA]." *Metropolitan Life*, 471 U.S. at 747.

Further, ERISA's claims procedures do not conflict with the notice-prejudice rule. Petitioner's reliance on *Pilot Life* on this point is thus misplaced.

In *Pilot Life*, the Court considered whether ERISA preempted a state law cause of action for improper claims processing. 481 U.S. at 43. That state law would have provided the plan participant with a remedy which ERISA did not provide. The Court held that the law was preempted because (1) it did not regulate insurance within the meaning of the saving clause, and (2) Congress

intended for ERISA's civil enforcement scheme to be exclusive. *Id.* at 57.

In contrast to the state law at issue in *Pilot Life*, the notice-prejudice rule is not a remedial provision in its own right, but rather a rule to be applied in conjunction with an action for benefits under an insured ERISA plan pursuant to 29 U.S.C. § 1132(a)(1)(B). Further, in contrast to Congress's careful listing of remedies under ERISA § 502(a), ERISA imposes no time limit on a participant's administrative claim. *See* 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1(c)-(g). Therefore, even if the conflict preemption analysis of *Pilot Life* were appropriate here, the holding in *Pilot Life* should not be read so expansively as to conclude that ERISA's claims procedures negate the effect of the saving clause in this case.

Boiled to its essence, Petitioner's sweeping allegation on pages 16-17 of its Brief that "ERISA's preemption clause bars all state law intrusion in the areas of fiduciary conduct and employee benefit plan administration" is an attempt to read out of the saving clause state laws that regulate any kind of insurance claims procedure. ERISA's substantive provisions, which are silent on the time limit for making an administrative claim, do not override the notice-prejudice rule which is otherwise saved from preemption. Because that state law does not conflict with ERISA, it should be enforced by affirming the Ninth Circuit's decision.

C. Congress Expressly Allowed For A "Disuniformity" Of ERISA Plan Regulation By Virtue Of The Saving Clause.

Finally, Petitioner and its supporting amici place undue reliance on the need for uniformity of employee benefit plan regulation through ERISA. When ERISA was enacted, Congress recognized and supported the continuation of state regulation of insurance through the saving clause. ERISA provides an opportunity for employers to design and implement employee benefit plans on a nationwide, uniform basis through the use of self-insured employee benefit plans which are exempt from state regulation pursuant to the deemer clause of ERISA, 29 U.S.C. § 1144(b)(2)(B).

This Court has previously rejected the "uniformity" argument propounded by Petitioner:

> We are aware that our decision results in a distinction between insured and uninsured plans, leaving the former open to indirect regulation while the latter are not. By so doing we merely give life to a distinction created by Congress in the "deemer clause," a distinction Congress is aware of and one it has chosen not to alter.
>
> We also are aware that appellants' construction of the statute would eliminate some of the disuniformities currently facing national plans that enter into local markets to purchase insurance. Such disuniformities, however, are the inevitable result of the congressional decision to "save" local insurance regulation.

Metropolitan Life, 471 U.S. at 747. *See also FMC Corp. v. Holliday*, 498 U.S. at 61-63.

Enforcement of the saving clause by affirming the Ninth Circuit's decision is thus consistent with the language and purpose of ERISA. Any challenge to that decision based on concerns of "disuniformity" "must be directed at Congress." *Metropolitan Life*, 471 U.S. at 747. Under existing law, the state law notice-prejudice rule is fully effective as to Petitioner and the decision below should thus be affirmed.

CONCLUSION

For the foregoing reasons, the decision of the United States Court of Appeals for the Ninth Circuit should be affirmed.

Respectfully submitted,

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IN THE
SUPREME COURT OF THE UNITED STATES
OCTOBER TERM, 1997

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Writ of Certiorari To The United States Court of Appeals For the Ninth Circuit

BRIEF *AMICUS CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS IN SUPPORT OF RESPONDENT

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AARP FOUNDATION LITIGATION

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No. 97-1868

IN THE
Supreme Court of the United States
OCTOBER TERM, 1997

UNUM LIFE INSURANCE COMPANY OF AMERICA,
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v.

JOHN E. WARD,
Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

BRIEF *AMICUS CURIAE* OF THE AMERICAN ASSOCIATION OF RETIRED PERSONS IN SUPPORT OF RESPONDENT

INTEREST OF *AMICUS CURIAE*

The American Association of Retired Persons (AARP) is a nonprofit membership organization of more than 30 million persons, age 50 or older, working or retired, that is dedicated to addressing the needs and interests of older Americans.[1/] AARP seeks through education, advocacy and service to enhance the quality of life for all by promoting independence, dignity and purpose. As a method of promoting

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[1/] No counsel for any party authored any portion of this brief. No persons other than AARP, its members, or its counsel have made a monetary contribution to the preparation and submission of this brief.

independence, AARP attempts to foster the economic security of individuals as they age by seeking to increase the availability, security, equity, and adequacy of public and private pension, health, disability, and other employee benefits.

AARP's members and other participants and beneficiaries in private, employer-sponsored employee benefit plans rely on the Employee Retirement Income Security Act (ERISA) to protect their rights under those plans. 29 U.S.C. § 1001 *et seq*. Contrary to its purpose, a statute that was designed to safeguard employee benefits has, all too frequently, been used to deprive employees of rights and protections they previously enjoyed under state law. Even after the Court's recent preemption trilogy,[2/] the lower courts still are struggling with the breadth of ERISA's preemption clause.[3/] These lower court decisions bear directly on the ability of participants and beneficiaries to bring their claims for benefits[4/] as well as

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[2/] *Boggs v. Boggs*, 117 S. Ct. 1754 (1997); *DeBuono v. NYSA-ILA Medical & Clinical Servs. Fund*, 520 U.S. 806 (1997); *California Division of Labor Standards Enforcement v. Dillingham Construction, N.A., Inc.*, 519 U.S. 316 (1997).

[3/] *Compare, e.g., Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *petition for cert. filed*, 67 U.S.L.W. 3376 (U.S. Nov. 23, 1998) (No. 98-889) *with Prudential Ins. Co. v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998). *See generally* Karen A. Jordan, *The Shifting Preemption Paradigm: Conceptual and Interpretive Issues*, 51 VAND. L. REV. 1149 (1998).

[4/] Approximately 61% of employed Americans are eligible for health benefits through employment-based health plans. *See* Sarah Snider & Paul Fronstin, Employee Benefit Research Inst., *Sources of Health Insurance and Characteristics of the Uninsured: Analysis of the March 1994 Current Population Survey*, EBRI ISSUE BRIEF NO. 158/SPECIAL REPORT SR-281, at 4 (Feb. 1995). In 1994, almost one-third of retirees (continued...)

states' attempt to provide better consumer protections for their citizens.

Given the reliance of petitioner UNUM Life Insurance Company of America and its *amici* on this Court's decision in *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), this case presents the Court with the opportunity to review its holding in *Pilot Life* in light of its recent preemption decisions.[5/] The decision in this case will have a direct and vital bearing on the economic security of AARP's members and other older Americans.[6/] In light of the significance of

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[4/](...continued)
reported current coverage under the health plan of their former employer. Pension and Welfare Benefits Admin., U.S. Dep't of Labor, *Retirement Benefits of American Workers: New Findings from the September 1994 Current Population Survey* 3 (Sept. 1995). Approximately 47% of Americans are covered by a pension plan or have prior plan vested benefits. *Id.* at 55, tbl. B7. Among private sector retirees aged fifty-five and older, 43% are receiving, have received, or expect to receive pension benefits from former employment. *Id.* at 47, tbl. B2.

[5/] AARP's brief assumes that the Court will find that California's notice-prejudice rule "relates to" an employee benefit plan, ERISA § 514(a), 29 U.S.C. § 1144(a), and that it is exempt from preemption under the saving clause. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). AARP's brief does not address the rule of law developed in *Elfstrom v. New York Life Ins. Co.*, 432 P.2d 731 (1967).

[6/] As part of its advocacy efforts to ensure, to the greatest extent possible, that participants and beneficiaries receive the benefit of ERISA's protections, AARP has participated as *amicus curiae* in numerous cases involving ERISA, including *Boggs v. Boggs*, 117 S. Ct. 1754 (1997); *California Division of Labor Standards Enforcement v. Dillingham Construction*, 519 U.S. 316 (1997); and *John Hancock Mutual Life Ins. Co. v. Harris Trust & Savings Bank*, 510 U.S. 86 (1993).

the issues presented by this case, AARP respectfully submits this brief *amicus curiae*.[2]

SUMMARY OF ARGUMENT

In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), this Court held that the civil enforcement provisions under ERISA § 502(a), 29 U.S.C. § 1132(a), were to be the exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper processing of a claim for benefits. The Court's analysis did not discuss traditional Supremacy Clause principles although this was the implicit basis for its holding.

In passing ERISA's preemption clause, Congress reserved power to legislate over the field of employee benefits, ERISA § 514(a), 29 U.S.C. § 1144(a), and then expressly restored power to the states to regulate insurance as applied to employee benefit plans. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). This express restoration of state power requires critical analysis and unmistakable Congressional intent before it can be found that a state insurance law is preempted by ERISA under the Supremacy Clause. U.S. Const. art. VI, cl. 2; *Pacific Gas & Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 206 (1983).

This Court recognized the balance between state insurance laws and ERISA when it found that "ERISA leaves room for complementary or dual federal and state regulation" and state law would only be superseded when the "dual regimes [could] not be harmonized or accommodated." *John Hancock Mutual Life Ins. Co. v. Harris Trust & Sav. Bank*, 510 U.S. 86, 98 (1993). In order to determine whether a state regulation is

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[2] The written consents of the parties have been filed with the Clerk of the Court pursuant to Supreme Court Rule 37.3.

complementary or can be harmonized, it is necessary to determine whether "'compliance with both federal and state regulations is a physical impossibility,'" or whether that "law 'stands as an obstacle to the accomplishment of the full purposes and objectives of Congress[.]'" *Gade v. National Solid Wastes Management Ass'n*, 505 U.S. 88, 98 (1992) (citations omitted).

California's notice-prejudice rule provides that an insurer may not deny a claim as untimely unless the insurer can show actual prejudice (other than payment of the claim itself or general untimeliness) resulting from the delay. This rule neither implicates nor impinges upon ERISA's enforcement scheme because it provides no additional remedies or an alternative enforcement mechanism. This rule also does not implicate ERISA's claims procedure because the notice-prejudice rule is a complementary interpretive rule which deems a claim to be timely filed. Thus, compliance with both state and federal laws is not a physical impossibility.

Moreover, the fact that federal and state laws are different does not mean that there is an impermissible conflict. ERISA is not absolute, but explicitly recognizes a role for state insurance regulation, thus permitting state insurance laws to supplement or complement ERISA's standards. *John Hancock*, 510 U.S. at 98. California's notice-prejudice rule provides additional time for a participant to have his or her claim deemed timely filed, thus protecting their rights, while still safeguarding the insurer from stale claims. There is no conflict or inconsistency with ERISA. Thus, California's notice-prejudice rule cannot be found to stand as an obstacle to the accomplishment and execution of Congressional purposes and objectives. *See id.* at 99.

ARGUMENT

I. RECENT PREEMPTION DECISIONS AND TRADITIONAL SUPREMACY CLAUSE ANALYSIS URGE A REEXAMINATION OF *PILOT LIFE*.

A. The Impact of *Pilot Life*'s Holding Cannot Be Underestimated.

In *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41, 43 (1987), this Court stated that the issue before it was whether ERISA "pre-empts state common law tort and contract actions asserting improper processing of a claim for benefits under an insured employee benefit plan." Mr. Dedeaux brought claims for tortious breach of contract, fraud in the inducement and breach of fiduciary duties against Pilot Life because it had reinstated and terminated his disability benefits several times during a three year period. Not only did he seek the benefits to which he was entitled, but he also sought damages for mental and emotional distress and punitive damages. *Id.* at 43-44.

After describing ERISA's statutory framework including ERISA's purpose of protecting participants and beneficiaries, the Court set forth the mechanics to analyze ERISA's preemption provisions. *Id.* at 45. First, it must be determined whether a state law relates to an employee benefit plan. ERISA § 514(a), 29 U.S.C. § 1144(a). Second, if the state law relates to a plan, it must be determined whether the state law is saved from preemption because it is a law that regulates insurance. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). Third, if the first two determinations are answered in the affirmative, then it must be determined whether a state law that "purport[s] to regulate insurance" deems an employee benefit plan to be an insurance company. ERISA § 514(b)(2)(B), 29 U.S.C. § 1144(b)(2)(B). Although it was unnecessary to the holding of *Pilot Life* in that the Court had found that the state law at issue was not saved as a

law regulating insurance, the Court added a fourth component to its preemption analysis -- even if the state law is saved because it is a law that regulates insurance, it will still be preempted if it directly conflicts with a provision of ERISA. 481 U.S. at 51-53.

The Court found that the civil enforcement provisions under ERISA § 502(a), 29 U.S.C. § 1132(a), were to be the exclusive vehicle for actions by ERISA plan participants and beneficiaries asserting improper processing of a claim for benefits. *Id.* at 52.[8] Any and all other state causes of actions for claims which fall within the scope of § 502(a) would pose an obstacle to the purposes and objectives of Congress. The Court relied upon the language and structure of the civil enforcement provisions and the legislative history. The Court characterized the civil enforcement scheme of § 502(a) as "one of the essential tools for accomplishing the stated purposes of ERISA." *Pilot Life*, 481 U.S. at 52. The Court stated that the civil enforcement scheme represented a balance between the need for prompt resolution of benefit claims against the encouragement of the formation of employee benefit plans. *Id.* at 54. The Court further explained that the legislative history showed Congress' expectation that a body of federal common law would develop. The Court opined that this expectation would be undermined if remedies available under ERISA could be supplemented or supplanted by state laws. *Id.* at 56. Thus, *Pilot Life* implicitly held, without significant analysis concerning the conflict resulting from concurrent state and federal powers, that a state law that is exempted from preemption under ERISA's saving clause

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[8] At least one commentator has suggested that this holding was not compelled by ERISA's language or its legislative history. Catherine L. Fisk, *The Last Article about the Language of ERISA Preemption? A Case Study of the Failure of Textualism*, 33 HARV. J. ON LEGIS. 35, 51-52 (1996).

could still be preempted under the Supremacy Clause because it conflicts with a substantive provision of ERISA.

The significance of *Pilot Life*'s holding cannot be underestimated. Not only have participants been unable to bring claims for intentional infliction of emotional distress, bad faith dealings, and other torts and to collect punitive and other extra contractual damages, but many participants have been left with no remedy at all. *E.g.*, *Degan v. Ford Motor Co.*, 869 F.2d 889, 895 (5th Cir. 1989) (characterization of this situation as "[b]etrayal [w]ithout [a] [r]emedy"). There has been more than one case where a plan has refused to provide a health benefit which is due and owing under the plan, until it is too late and the participant dies, leaving the participant's estate with no remedy. *E.g.*, *Andrews-Clarke v. Travelers Ins. Co.*, 984 F. Supp. 49 (D. Mass. 1997) (insurance company refused to authorize alcohol detoxification for more than 5 days in a row although policy permitted 30 days; participant committed suicide, and estate had no remedy).

Moreover, recent cases dealing with managed care issues such as utilization review have required federal courts to enter the traditional state area of medical malpractice. These cases have revolved around the characterization of the breach to decide whether a state law claim may proceed. If the breach is characterized as improper processing of benefits, the state claim is preempted under *Pilot Life*. *E.g.*, *Corcoran v. United Healthcare, Inc.*, 965 F.2d 1321 (5th Cir. 1992) (suit for wrongful death of fetus and malpractice against utilization review company's refusal to authorize hospitalization to monitor pregnancy was preempted because its decisions were benefit determinations). If it is characterized as negligent provision of medical care or a quality of care claim, then the claim is not preempted. *E.g.*, *Dukes v. U.S. Healthcare, Inc.*, 57 F.3d 350 (3d Cir. 1995) (suit for refusal to perform blood tests and malpractice for allowing patient's condition to deteriorate resulting in stillbirth was not preempted since

quality of care is an area of traditional state regulation and ERISA is silent).

The significant changes in the health care industry since ERISA's passage has led to increased state legislative activity to attempt to provide increased consumer protections. *See, e.g.*, *Washington Physicians Service Ass'n v. Gregoire*, 147 F.3d 1039 (9th Cir. 1998), *petition for cert. filed*, 67 U.S.L.W. 3376 (U.S. Nov. 23, 1998) (No. 98-889) (State of Washington's alternative provider statute not preempted in its application to HMOs which sell insurance); *Prudential Ins. Co. v. National Park Medical Center, Inc.*, 154 F.3d 812 (8th Cir. 1998) (Arkansas statute ensuring that participants may see the physician of their choice specifically excludes ERISA plans and therefore is preempted); *Stuart Circle Hosp. Corp. v. Aetna Health Management*, 995 F.2d 500 (4th Cir. 1993) (Virginia any willing provider statute is saved from preemption because it "regulates the business of insurance"); *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 12 F. Supp.2d 597 (S.D. Tex. 1998) (independent review provision mandates the administration of employee benefits and therefore relates to an ERISA plan; statute is not saved because it is not limited to the insurance industry); *American Drug Stores, Inc. v. Harvard Pilgrim Health Care, Inc.*, 973 F. Supp. 60 (D. Mass. 1997) (Massachusetts any willing provider statute was not preempted by ERISA); *Community Health Partners, Inc. v. Commonwealth*, 14 F. Supp.2d 991 (W.D. Ky. 1998) (Kentucky any willing provider statute specifically references ERISA plans but is not preempted because all plans are affected and statute is no different than mandated benefit statute). *Pilot Life* has acted as a significant barrier to these attempts and has resulted in creative judicial decisions to deal with its effects. *See generally* Nicole Weisenborn, *ERISA Preemption and Its Effect on State Health Reform*, 5-FALL KAN. J.L. & PUB. POL'Y 147 (1995); Wendy E. Parmet, *Regulation and Federalism: Legal Impediments to State Health Care Reform*, 19 AM. J.L. & MED. 121 (1993).

B. Under ERISA, State Laws Regulating the Business of Insurance Are Unique and Require a More Critical Analysis than Other Types of State Laws.

When enacting ERISA's preemption section, Congress expressly provided that ERISA preempts state laws relating to employee benefit plans. ERISA § 514(a), 29 U.S.C. § 1144(a). But Congress did something more; it created an exception explicitly ceding back power to the states to enact legislation concerning employee benefit plans if the legislation regulated the business of insurance. ERISA § 514(b)(2)(A), 29 U.S.C. § 1144(b)(2)(A). AARP contends that such express restoration of state power requires a more critical analysis and irrefutable Congressional intent before it can be found that a state insurance law is preempted by ERISA under the Supremacy Clause.[2/] U.S. Const. art. VI, cl. 2; *Pacific Gas & Elec. Co. v. State Energy Resources Conservation & Dev. Comm'n*, 461 U.S. 190, 206 (1983).

Indeed, this Court has recognized this critical analysis. In its most recent case dealing with ERISA preemption and the insurance industry, this Court recognized that "ERISA leaves room for complementary or dual federal and state regulation[.]" *John Hancock*, 510 U.S. at 98. Significantly, this Court held that generally state law governing insurance is not displaced. Federal preemption would only occur "'where compliance with both federal and state regulations is a physical impossibility,'" *Boggs v. Boggs*, 117 S. Ct. 1754, 1762 (1997) (quoting *Gade v. National Solid Wastes*

[2/] See Stephen A. Gardbaum, *The Nature of Preemption*, 79 CORNELL L. REV. 767 (1994), arguing that there should be no preemption doctrine and providing an in-depth historical review of preemption cases. See generally Kenneth Starr, et al., American Bar Ass'n, *The Law of Preemption: A Report of the Appellate Judges Conference* (1991) for issues surrounding preemption.

Management Ass'n, 505 U.S. 88, 98 (1992)), or "'where [that] law stands as an obstacle to the accomplishment of the full purposes and objectives of Congress[.]'" *John Hancock*, 510 U.S. at 99 (first alteration in original) (quoting *Silkwood v. Kerr-McGee Corp.*, 464 U.S. 238, 248 (1984)). In *Hancock*, the Court "call[ed] for federal supremacy [only] when the two regimes cannot be harmonized or accommodated." *Id.* at 98. In essence, the Court construed ERISA to set minimum standards which insurance laws can complement or supplement.

And so, the issue in this case is whether compliance with California's notice-prejudice rule and ERISA can be harmonized or accommodated. AARP submits that these state and federal laws can be harmonized. In this endeavor, we must determine whether compliance with both laws is a physical impossibility and whether the notice-prejudice rule stands as an obstacle to the accomplishment of the full purposes and objectives of Congress. We address each of these in turn.

1. Compliance with both California's notice-prejudice rule and ERISA is not a physical impossibility.

California's notice-prejudice rule provides that an insurer may not deny a claim as untimely unless it can show actual prejudice (other than payment of the claim itself or general untimeliness) resulting from the delay. This rule neither implicates nor impinges upon ERISA's enforcement scheme. It does not provide any additional remedies beyond those which ERISA provides. All this rule does is to deem a claim timely filed so that participants may receive benefits under the plan. Moreover, if their claim is denied, participants must still file suit under ERISA § 502(a), 29 U.S.C. § 1132(a), in order to receive their benefit. The notice-prejudice rule is not an alternative enforcement mechanism. Finally, although fiduciaries may be obligated to administer their plans in

accordance with their written terms, *see* ERISA § 404(a)(1)(D), 29 U.S.C. § 1104(a)(1)(D), the plans must be administered in accordance with other ERISA provisions and other federal and state laws. *Cf. Arizona Governing Comm. for Tax Deferred Annuity and Deferred Compensation Plans v. Norris*, 463 U.S. 1073 (1983) (paying women less pension benefit than men under state plan administered by companies using only sex-based mortality tables which accounted for greater life expectancy violated Title VII); *Los Angeles Dep't of Water & Power v. Manhart*, 435 U.S. 702 (1978) (holding that an employer had violated Title VII by requiring its female employees to make larger contributions to a pension fund than male employees in order to obtain the same monthly benefits upon retirement). Consequently, the only provision of ERISA which California's notice-prejudice rule potentially implicates is ERISA's claims procedure. ERISA § 503, 29 U.S.C. § 1133; 29 C.F.R. § 2560.503-1.

AARP submits that there is no direct conflict between California's notice-prejudice rule and ERISA's claims procedure. Compliance with both is not a physical impossibility. *Compare McCarty v. McCarty*, 453 U.S. 210 (1981) (federal law prohibiting attachment of military retirement pay preempted state community property laws permitting such attachment); *Hisquierdo v. Hisquierdo*, 439 U.S. 572 (1979) (federal law prohibiting attachment of railroad retirement income preempted state community property laws expressly permitting division of same). Indeed, an insurer and/or plan may comply both with this rule and with ERISA's claim procedure.

Recent cases illustrate the high burden which must be met in order for the Court to find that compliance with both federal and state laws is a physical impossibility. In *John Hancock*, this Court rejected the argument that ERISA and state insurance laws were at odds and "would pose irreconcilable conflicts between state and federal regulatory schemes" concerning the regulation of insurance general

account contracts. 510 U.S. at 97. The Court did not believe that ERISA's fiduciary requirement to act solely in the interest of participants and state insurance requirements to consider the interests of all its contract holders, creditors and shareholders were in conflict, but rather these requirements could exist as dual federal and state regulation. *Id.* at 97-98.

In contrast is *Boggs v. Boggs*, 117 S. Ct. 1754 (1997), in which this Court found that there was a direct clash between a state law permitting testamentary transfer by a predeceased nonparticipant spouse and ERISA's requirement of a survivor's annuity. The Court held that it would undermine ERISA's mandated survivor annuity to allow a predeceased nonparticipant spouse to defeat by testamentary transfer the surviving spouse's entitlement to the annuity ERISA guaranteed her. *Id.* at 1761.

In this case, it is clear that an insurer may comply with both California's notice-prejudice rule and ERISA's claims procedure. First, ERISA requires that an employee benefit plan provide a claims procedure which a participant may use to appeal the denial of a claim for benefits. The claims procedure must provide full and fair review of the appeal. ERISA § 503, 29 U.S.C. § 1133. Second, the Secretary of Labor proscribed regulations interpreting ERISA's claim procedure under Section 503. These claims procedures provide the minimum standards under which an employee benefit plan must process claims. 29 C.F.R. § 2560.503-1 (regulation sets forth minimum requirements which the benefit claims procedures of ERISA plans must meet to be deemed reasonable); Claims Procedure for Employee Benefit Plans, 42 Fed. Reg. 27,426 (1977) (preamble explaining operation and purpose of regulation). However, the statute and claims procedure regulations are silent on the time by which participants must file their claim. The only requirement is that the amount of time be reasonable. Consequently, in this case, the claims procedure in UNUM's disability policy provided a time frame in which to file his claim. All

California's notice-prejudice rule does is to permit a claim to be deemed timely filed unless the insurer can show it was actually prejudiced. California's notice-prejudice rule acts as an interpretive or "deeming" rule in determining whether an insurance claim has been timely filed.

Because an insurer can physically comply with both California's notice-prejudice rule and ERISA's claims procedure, there is no direct conflict between these two laws.

2. California's notice-prejudice rule does not stand as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.

The second prong for determining whether there is a conflict between state and federal law is much more nebulous than the direct conflict or physical impossibility test. The "stands as an obstacle" prong forces the Court to determine the intent of Congress, which is not dissimilar to field preemption and the determination whether Congress intended to occupy the field. Paul Wolfson, *Preemption and Federalism: The Missing Link*, 16 HASTINGS CONST. L.Q. 69 (1988). However, because Congress expressly ceded power back to the states to regulate the business of insurance, AARP contends that it is crucial not to conflate field and conflict preemption principles.[10/] Thus, the Court's test of whether the state insurance law can be harmonized and accommodated with ERISA recognizes this distinction and strikes the right

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[10/] In contrast to conflict preemption, field preemption leaves no room for states to supplement federal regulation because Congressional intent is inferred from the comprehensiveness of the federal regulations. *English v. General Electric Co.*, 496 U.S. 72, 78-79 (1990).

balance in determining whether Congress intended to oust state insurance law.[11/] *John Hancock*, 510 U.S. at 97-98.

> Analysis of whether a state law frustrates the attainment of Congress' objectives involves several steps: an identification of congressional purposes, an assessment of the effect of the state law and a determination whether that effect 'stands as an obstacle' to one of the purposes underlying the federal law.

Jordan, *supra*, at 1200.

In analyzing Congress' purposes, the Court must look not only at the stated purposes but at the structure of the statute as a whole.[12/] ERISA's declared principal purpose is "to protect plan participants and beneficiaries . . . ." *Boggs*, 117 S. Ct. at 1762 (*citing Shaw v. Delta Air Lines, Inc.*, 463 U.S. 85, 90 (1983)); ERISA § 2(b), 29 U.S.C. § 1001(b). The purpose of ERISA's claims procedure and its interpreting regulations is to provide minimum standards to protect participants and beneficiaries. *See* 29 C.F.R. § 2560.503-1; Claims Procedure for Employee Benefit Plans, 42 Fed. Reg. 27,426 (1977). Consequently, AARP contends that the fact that federal and state laws are different does not mean that there is an impermissible conflict. In this instance, we would further contend that state insurance laws may set additional

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[11/] In determining whether there is preemption under the Supremacy Clause, uniformity is not an appropriate purpose to be considered. However, uniformity is an appropriate purpose to be considered in the context of field preemption. Karen A. Jordan, *The Shifting Preemption Paradigm: Conceptual and Interpretive Issues*, 51 VAND. L. REV. 1149, 1174-76 (October 1998).

[12/] Characterization of the federal and state purposes is determinative of the outcome of the analysis. Erwin Chemerinsky, *Constitutional Law: Principles and Policies*, § 5.2 (1997).

standards to ERISA's minimum standards. In other words, ERISA is not absolute, but explicitly recognizes a role for state insurance regulation, thus permitting state insurance laws to supplement or complement ERISA's standards. *John Hancock*, 510 U.S. at 97-98; *cf. Wisconsin Public Intervenor v. Mortier*, 501 U.S. 597 (1991) (federal law set the minimum standard for pesticide use, and thus did not preempt local rules); *Florida Lime & Avocado Growers, Inc. v. Paul*, 373 U.S. 132 (1963) (federal law did not preempt state law setting other standards for measuring the maturity of avocados).

This analysis is consistent with this Court's decisions in *FMC Corp. v. Holliday*, 498 U.S. 52 (1990), and *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724 (1985). In *Metropolitan Life*, this Court held that ERISA did not preempt a state law mandating minimum mental health benefits because it was exempted under the saving clause. *Id.* at 744.[13/] The court did not find that state laws regulating the substantive terms of group health insurance contracts conflict with ERISA. Similarly, in *FMC Corp.*, this Court held that a state anti-subrogation clause was preempted as applied to a self-funded ERISA plan. The Court emphatically stated:

> [I]f the plan is insured, a State may regulate it indirectly through regulation of its insurer and its insurer's insurance contracts; if the plan is uninsured, the State may not regulate it. As a

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13/ We note that Congress has recently passed certain mandated benefit laws. Newborns' and Mothers' Health Protection Act of 1996, Pub. L. No. 104-204, 110 Stat. 2935, 2935-39 (codified at ERISA § 711, 29 U.S.C.A. § 1185 (West 1999)) (minimum hospital length of stay for postpartum care); Mental Health Parity Act of 1996, Pub. L. No. 104-204, 110 Stat. 2944, 2944-47 (codified at ERISA § 712, 29 U.S.C.A. § 1185a (West 1999)) (prohibiting annual or lifetime limits on mental health benefits that are lower than any comparable limits for medical and surgical benefits). Unlike the law at issue in *Metropolitan Life*, these laws apply to both insured and self-funded ERISA plans.

> result, employers will not face "'conflicting or inconsistent State and local regulation of employee benefit plans.'"

FMC Corp., 498 U.S. at 64 (*quoting Shaw*, 463 U.S. at 99). Clearly, the Court implicitly found that state insurance regulation did not lead to conflict or inconsistency with ERISA.

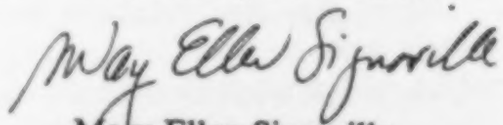
Here, the state insurance law protects participants and beneficiaries by providing a complementary interpretive rule which will deem their claims to be timely filed. The insurer obviously meets the ERISA's claims procedure standards by providing a reasonable period of time to file a claim. The effect of this state law is to provide additional time for a participant to have his or her claim deemed timely filed, while still protecting the insurer from stale claims. There is no conflict or inconsistency with ERISA. Thus, California's notice-prejudice rule cannot be found to stand as an obstacle to the accomplishment and execution of Congressional purposes and objectives. Instead, this law can easily be harmonized or accommodated with ERISA.

CONCLUSION

For the above reasons, AARP urges the Court to hold that California's notice-prejudice rule should not be preempted under the Supremacy Clause because it can be harmonized and accommodated with ERISA's claims procedure.

January 8, 1999

Respectfully submitted,



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In the

Supreme Court of the United States

October Term, 1998

UNUM LIFE INSURANCE COMPANY OF AMERICA,
Petitioner,

v.

JOHN E. WARD,
Respondent.

On Writ of Certiorari
To the United States Court of Appeals
For the Ninth Circuit

BRIEF OF THE STATES OF TEXAS, ALABAMA, ARIZONA, ARKANSAS, CALIFORNIA, COLORADO, CONNECTICUT, DELAWARE, FLORIDA, GEORGIA, HAWAII, IDAHO, ILLINOIS, INDIANA, IOWA, LOUISIANA, MAINE, MARYLAND, MASSACHUSETTS, MICHIGAN, MINNESOTA, MISSOURI, MONTANA, NEVADA, NEW JERSEY, NEW MEXICO, NEW YORK, NORTH CAROLINA, NORTH DAKOTA, OHIO, OKLAHOMA, OREGON, PENNSYLVANIA, RHODE ISLAND, SOUTH CAROLINA, TENNESSEE, UTAH, VERMONT, WASHINGTON, WEST VIRGINIA, WYOMING AND THE TERRITORY OF PUERTO RICO AS AMICI CURIAE IN SUPPORT OF RESPONDENT

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INTEREST OF THE AMICI CURIAE

The 42 amici curiae states, through their attorneys general, respectfully submit this brief in support of Respondent Ward. The states have a vital interest in ensuring that the scope of preemption by the Employee Retirement Income Security Act of 1974 (ERISA) is not extended beyond Congress's intent. Prior to this Court's ruling in *New York State Conference of Blue Cross & Blue Shield v. Travelers Insurance Co.*, 514 U.S. 645, 654 (1995), circuit courts took such an expansive view that "we could scarcely see the end of ERISA's preemptive reach." *California Div. of Labor Standards Enforcement v. Dillingham Constr., N.A.*, 519 U.S. 316, 331-32 (1997). As a result, this Court ruled in *Travelers* that absent the express intent of Congress to preempt, traditional state powers can and should coexist with federal regulation. Now, in response to Petitioner UNUM's claim of a right to conduct its insurance business without regard for state law, this Court is needed once again to ensure that Congress's intent is fulfilled.

SUMMARY OF ARGUMENT

Congress enacted ERISA in 1974 for one paramount purpose: to protect employees' interests in pension and welfare plans from employer abuse and mismanagement. It is therefore ironic that insurers like UNUM now seek to use ERISA not as a shield to protect employees, but as a sword to eviscerate the protections of state law. States have long protected their citizens through their insurance laws – laws which Congress deferred to by expressly providing that "any" state law "which regulates insurance" is saved from ERISA preemption. Yet even as UNUM seeks to profit by selling and administering state-licensed insurance products for ERISA plans, it invokes ERISA to defeat virtually all state regulation of these products.

1. California's notice-prejudice rule provides that an insurer may not deny benefits on the ground that the insured's claim was untimely filed unless the insurer can demonstrate that it was prejudiced by the untimeliness. Our ERISA analysis of this rule starts with the broad language of the saving clause, which preserves "any" state law "which regulates insurance." This Court has consistently held that whether a state law "regulates insurance" is a matter of common sense. The road map for this approach is set forth in *Securities & Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 460 (1969), which states that "[t]he relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement – these [are] the 'core of the business of insurance.'" The notice-prejudice rule goes to the heart of the insurance relationship – it determines whether a disabled beneficiary under an insured group plan gets any of the benefits for which the policy was purchased and its premiums paid. Thus, as a matter of common sense, it "regulates insurance."

UNUM, however, argues that a state law does not regulate insurance unless it satisfies all three factors (the "*Pireno* factors") developed to determine whether a practice is exempt from federal antitrust laws under the McCarran-Ferguson Act. This is contrary to this Court's decisions, which use the *Pireno* factors to augment – not undermine – the common sense approach. It is also inconsistent with the bases of the statutes, as the ERISA saving clause and the McCarran-Ferguson antitrust exemption serve entirely different purposes. Moreover, UNUM's argument would be directly contrary to Congress's intent to preserve essential state laws that regulate insurance relationships, policies and the interpretation and enforcement of insurance contracts.

UNUM compounds its misuse of the *Pireno* factors by interpreting each of them so restrictively that few if any state insurance laws could survive them. UNUM contends that no state law regulating claims determination and the payment of benefits spreads or transfers risk (the first *Pireno* factor). UNUM could not be more wrong: laws governing whether claims are honored and benefits are paid embody the extent and allocation of the risk transferred. UNUM contends that a state law regulating the administration of an insurance policy somehow does not affect the insurance policy relationship (the second *Pireno* factor), yet the saving clause makes no distinction between laws regulating administration and those regulating benefits. And UNUM contends that any insurance law having its genesis in the common law is not a law aimed at the insurance industry (the third *Pireno* factor) – as if to suggest that state legislators and courts should regulate insurance by first jettisoning any notion that such laws might have roots or analogues in the common law. In short, a reasonable application of the *Pireno* factors – unlike UNUM's – could only support a holding that the notice-prejudice rule regulates insurance.

Finally, UNUM argues that when an insurer administers an insurance policy for an ERISA plan, all state regulation of these activities is barred by the deemer clause. The deemer clause, however, merely bars states from certain regulation of self-insured plans. Indeed, UNUM ignores the fundamental distinction the deemer clause creates between self-insured plans and insured plans like the one at issue here.

2. Contrary to UNUM's argument, neither the notice-prejudice rule nor the *Elfstrom* rule conflicts with any substantive provision of ERISA. Ward's suit against UNUM states an ERISA cause of action for payment of benefits due under the UNUM disability insurance policy that funds his

employer's plan – a policy issued pursuant to California insurance law, including the notice-prejudice and *Elfstrom* rules. Thus, *Pilot Life Insurance Co. v. Dedeaux*, 481 U.S. 41 (1987), which involved a state law cause of action seeking damages for wrongful denial of benefits, is readily distinguishable.

UNUM's second argument asserting substantive conflict with ERISA is probably its most extreme: that California's insurance laws conflict with ERISA's requirement that fiduciaries administer plans "in accordance with" their written terms and pay benefits only if they are "due" under those terms. Thus, according to UNUM, ERISA gives insurance companies a license to violate state insurance law at will, simply by inserting contrary language in policies sold to ERISA plans. Surely Congress did not intend ERISA to empower insurers to write their own laws. Finally, the notice-prejudice and *Elfstrom* rules do not conflict with ERISA provisions regarding plan compliance with claims regulations promulgated by the Secretary of Labor.

3. The Ninth Circuit correctly held that the *Elfstrom* rule does not "relate to" ERISA plans and thus is not preempted. *Elfstrom* applies ordinary state common law agency principles in the insurance context, including the relationship between insurers and any third parties involved in policy administration. Because it is indifferent to the identity of those third parties, *Elfstrom* does not refer to or depend on the existence of ERISA plans. *Elfstrom* does not dictate or restrict any administrative or benefit choice that ERISA plans may make – it neither compels nor prohibits their choices concerning involvement in insurance policy administration. *Elfstrom* does not even indirectly dictate ERISA plan choices, since it does not restrict insurers' options in this regard either.

Elfstrom does result in the imposition of legal consequences upon insurance companies like UNUM who choose to involve others as their agents in policy administration, in that such insurers may have to pay claims they would otherwise have denied. This consequence, however, is not imposed on the ERISA plan, but on the insurer as an entity which, by contractually assuming the plan's risk of loss, is engaged in the business of insurance. Whatever indirect economic impact this may have on ERISA plans is insufficient to "relate to" them for preemption purposes.

ARGUMENT

I. THE NOTICE-PREJUDICE RULE "REGULATES INSURANCE" AND IS THEREFORE SAVED FROM EXPRESS PREEMPTION UNDER ERISA'S SAVING CLAUSE

The Ninth Circuit correctly held that California's notice-prejudice rule is saved from preemption by ERISA's saving clause because it regulates insurance. UNUM levies three basic arguments against the circuit court's conclusion. First, UNUM asserts that a state law does not regulate insurance unless it satisfies all three factors developed to determine whether a practice is exempt from federal antitrust laws under the McCarran-Ferguson Act (the "*Pireno* factors").[1] Pet. Br. 22. Second, UNUM constructs exceedingly high hurdles that state laws must meet to satisfy each of the three *Pireno* factors. Few state insurance laws could clear them, and none that pertain to

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[1] These factors were described in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 128 (1982), and are commonly referred to as the *Pireno* factors.

the determination and payment of insurance claims. *Id.* at 23-29. Third, UNUM asserts that even if the notice-prejudice rule "regulates insurance," it is not saved from preemption because the "deemer clause" bars state regulation of the administration of ERISA plans even when undertaken by outside insurance companies. *Id.* at 36-38.

Adopting any of UNUM's positions would conflict with Congress's express intent by dramatically reducing the scope of ERISA's saving clause, and removing vast portions of the insurance industry from traditional state regulation. Applying the proper analysis, the ERISA saving clause plainly applies to the notice-prejudice rule.

A. The ERISA Saving Clause Saves from Preemption State Laws That, as a Matter of "Common Sense," Regulate Insurance Such as Laws That Regulate Insurance Relationships, Types of Insurance Policies, and the Interpretation and Enforcement of Insurance Contracts

1. A "common sense" reading of the ERISA saving clause is consistent with congressional intent and has been adopted by this Court

Congress expressly saved state insurance laws in ERISA. Although Congress preempted state laws that "relate to" employee benefit plans (ERISA plans), Congress provided in ERISA's saving clause that "[e]xcept as provided in [the deemer clause], nothing in this subchapter shall be construed to exempt or relieve any person from any law of any State which *regulates insurance*, banking, or securities." 29 U.S.C. §1144(b)(2)(A) (emphasis added). Through this provision, Congress expressed its intent that states continue to exercise their traditional powers in the field of insurance. Regardless of

whether a state statute "relates to" an ERISA plan, the "ERISA plan is . . . bound by state insurance regulations insofar as they apply to the plan's insurer." *FMC Corp. v. Holliday*, 498 U.S. 52, 61 (1990).

This Court has recently reaffirmed the starting presumption that Congress did not intend to supplant state law, especially in areas traditionally left to state regulation. *Travelers*, 514 U.S. at 654; *Dillingham*, 519 U.S. at 331-32; *De Buono v. NYSA-ILA Medical & Clinical Serv. Fund*, 520 U.S. 806, 814 (1997). Where, as here, Congress expresses its intent to save from preemption state laws that regulate insurance, there is no basis to impose a restrictive interpretation of the clause. *Metropolitan Life Ins. Co. v. Massachusetts*, 471 U.S. 724, 745 (1985). A narrow, artificial reading of the term "regulates insurance" would be inconsistent with that intent, and finds no support in the language of the saving clause or ERISA generally.

This Court has effectuated Congress's intent by consistently holding that whether a state law "regulates insurance" under ERISA is a matter of "common-sense." *Pilot Life Ins. Co. v. Dedeaux*, 481 U.S. 41, 50 (1987); *Metropolitan Life*, 471 U.S. at 740. The amici states submit that this Court's opinion in *Securities & Exchange Commission v. National Securities, Inc.*, 393 U.S. 453, 460 (1969), which the Court quoted in *Metropolitan Life*, 471 U.S. at 743-44, provides the road map as to what types of laws regulate insurance as a matter of common sense: "The relationship between insurer and insured, the type of policy which could be issued, its reliability, interpretation, and enforcement – these were the 'core of the business of insurance.'" Laws regulating an insurance relationship, types of insurance policies and the interpretation and enforcement of insurance contracts address the "core of the business of insurance," and are, therefore, laws that "regulate insurance" under the ERISA saving clause.

Accordingly, in *Metropolitan Life*, this Court held that a state law mandating that insurance companies provide certain coverages "regulates insurance" as a matter of common sense and was thus saved from preemption. 471 U.S. at 740. The Court reasoned that the mandated-benefit law regulated the terms of insurance contracts and that Congress expressly reserved the regulation of insurance contracts to the state. The Court observed that, "[b]y exempting from the saving clause laws regulating insurance contracts that apply directly to benefit plans, the deemer clause makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the saving clause." *Id.* at 741. That general reading of the ERISA saving clause – that it saves laws that "regulate insurance contracts" – encompasses those types of insurance regulation that address "the core of the business of insurance" as described in *National Securities*. There is no basis in the words of ERISA, or any legal or policy reason, that a state regulation of an underlying insurance transaction must meet any additional test.

2. This Court has never required that the three *Pireno* factors be met for a law to "regulate insurance," and has used them only as a secondary analysis

a. Only after first concluding that the mandated-benefit law was a law regulating insurance saved from preemption did the Court in *Metropolitan Life* consider cases analyzing the antitrust exemption clause in the McCarran-Ferguson Act. The insurance company in *Metropolitan Life* sought to evade application of a state insurance law by claiming that the mandated-benefit law was not traditional insurance. After holding that the saving clause is not limited to traditional insurance laws, but includes innovative laws, the Court

nevertheless went on to use analysis applicable to the antitrust clause of the McCarran-Ferguson Act to find the mandated-benefit law to be traditional insurance regulation. 471 U.S. at 742-43. Specifically, the Court supported its conclusion by applying the three factors outlined in *Union Labor Life Insurance Co. v. Pireno*, 458 U.S. 119, 128 (1982), a case involving whether a health insurer's use of a peer review committee was exempt from federal antitrust laws.[2]

This Court, however, has *never* held that a state law is saved from ERISA preemption only if it meets *both* the common-sense definition of regulating insurance *and* all or some of the three *Pireno* criteria. Indeed, in *Pireno* itself, this Court noted that all three criteria need not be met for "the business of insurance" to be exempt from the federal antitrust laws, expressly stating that "none of these criteria is necessarily dispositive in itself." 458 U.S. at 128. Moreover, after the decisions in *Metropolitan Life* and *Pilot Life*, the Court held that the Pennsylvania antisubrogation law, a law regulating an insurance contract, was saved from preemption without ever considering the *Pireno* factors. *FMC Corp.*, 498 U.S. at 60-61. UNUM, and the several lower court decisions upon which it relies, are therefore mistaken in contending that this Court has required that all three *Pireno* factors be met before a state insurance regulation may be saved from preemption.

b. More fundamentally, the ERISA saving clause and the antitrust exemption of the McCarran-Ferguson Act are worded differently and serve different purposes. Narrowing the scope of the ERISA saving clause to conform to limits on the application of the McCarran-Ferguson antitrust exemption

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[2] Those factors are whether the law spreads risk, is an integral part of the policy relationship, and is limited to entities within the insurance industry. *Pireno*, 458 U.S. at 129.

mistakenly equates the two provisions. *Pireno* addressed the second clause of 15 U.S.C. §1012(b), which exempts from the antitrust laws "the business of insurance." The goal of that provision of the McCarran-Ferguson Act was not to grant the states broad regulatory authority over the field of insurance; it was to protect the insurance business itself by "carv[ing] out only a narrow exemption . . . from the federal antitrust laws." *United States Dep't of Treasury v. Fabe*, 508 U.S. 491, 505 (1993). By contrast, the ERISA saving clause preserves state authority to regulate the insurance industry free of preemption. There is no logical or policy reason why determining whether a state statute "regulates insurance," and thus is not preempted by ERISA, should be resolved by applying criteria used to determine whether a business practice is in the "business of insurance" such that it is not subject to the federal antitrust laws.

To the extent analysis of the McCarran-Ferguson Act is appropriate, the first clause of §1012(b), not the second, is the relevant provision. The first clause of §1012(b) reserves to the states the power to regulate insurance and provides that federal law shall not "supersede any law enacted by any state for the purpose of regulating the business of insurance." This provision's purpose – like the purpose of the ERISA saving clause – is to *preserve* state power. It follows that this Court's interpretation of the first clause of the McCarran-Ferguson Act – undertaken in *National Securities*, *supra* – is more useful in analyzing the ERISA saving clause.

In *Fabe*, the Court held that the analysis in *Pireno* (which addressed the second clause of §1012(b)) does not resolve whether a state statute "regulat[es] the business of insurance" and thus may not be superseded by federal law under the first clause. 508 U.S. at 504-505. Just as the three *Pireno* criteria do not control the first clause of the McCarran-Ferguson Act,

those three criteria should not control the ERISA saving clause. The proper view is that the *Pireno* factors "are simply relevant considerations or guideposts, not essential elements of a three-part test that must each be satisfied for a law to escape preemption." *Washington Physicians Serv. Ass'n v. Gregoire*, 147 F.3d 1039, 1047 (9th Cir. 1998).

c. A rule requiring that all three *Pireno* factors be met before a state statute is found to "regulate insurance" could – contrary to *Metropolitan Life* and *National Securities* – prevent the ERISA saving clause from saving myriad state laws that regulate insurance relationships, types of insurance policies and the interpretation and enforcement of insurance contracts. A number of lower courts, however, have rigidly applied the *Pireno* factors to erroneously find that state insurance laws that regulate insurance relationships and contracts do not regulate insurance for purposes of the ERISA saving clause. Examples of state laws mistakenly found not to regulate insurance are laws that address the reliability of policies by prohibiting insurance company misrepresentations,[3] the fundamental rule of insurance contract construction that an ambiguous policy is construed against the insurer,[4] laws regarding when insurance policies may be enforced (*e.g.*, when an insurance company

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[3] *See DeBruyne v. Equitable Life Assurance Soc.*, 920 F.2d 457, 468-70 (7th Cir. 1990) (reasoning that laws prohibiting misrepresentations do not spread risk).

[4] *See Brewer v. Lincoln Nat'l Life Ins. Co.*, 921 F.2d 150, 153 (8th Cir. 1990) (citing *McMahan v. New England Mut. Life Ins. Co.*, 888 F. 2d 426, 429 (6th Cir. 1989)) (the rule "does not effect a spreading or transferring of policyholders' insurance risk, but rather forces the insurer to bear the legal risks associated with ambiguous policy language"), *cert. denied*, 501 U.S. 1238 (1991).

may rescind a policy),[5] and laws regulating Health Maintenance Organizations (HMOs).[6] Most lawyers, legislators and lay persons would consider each of those laws to be laws regulating insurance. Each squarely regulates an insurance relationship, and addresses the "core of the business of insurance" as described in *National Securities*.

B. UNUM's analysis of the individual *Pireno* factors erroneously narrows them to such a degree that few insurance laws would satisfy any of them

Although the *Pireno* factors are not dispositive of whether a state insurance law is saved from preemption under the ERISA saving clause, those factors are used to support what common sense reveals. *Metropolitan Life*, 471 U.S. at 742-43. Moreover, misapplication of the *Pireno* factors has led to many of the erroneous decisions by the lower courts. For these reasons, it is necessary to respond to UNUM's proposed interpretation of the three factors, none of which is correct.

1. Spreading of risk. UNUM relies upon this Court's statement in *Pireno*, 458 U.S. at 130, that the "transfer of risk from insurer to insured is effected by means of the contract between the parties . . ., and . . . is complete at the time that the contract is entered." Pet. Br. 24. Taken to its literal extreme, as UNUM and some lower courts have, that statement means

[5] *See Davies v. Centennial Life Ins. Co.*, 128 F.3d 934, 941 (6th Cir. 1997) (holding they do not shift policyholder risk, but merely spread the risk of innocent misrepresentation); *Tingle v. Pacific Mutual Ins. Co.*, 996 F.2d 105, 108 (5th Cir. 1993) (same).

[6] *See, e.g., O'Reilly v. Ceuleers*, 912 F.2d 1383, 1389 (11th Cir. 1990) (holding that HMOs do not spread risk); *but see Cellilli v. Cellilli*, 939 F. Supp. 72, 77 (D. Mass. 1996) (holding that HMOs spread risk).

that no state insurance law regulating the performance of an insurance contract affects the spreading of risk. But such laws obviously do affect the transfer of risk; indeed, the performance of an insurance contract is the embodiment of the kind and amount of risk being transferred. For this reason, this Court in *Fabe* clarified that the statement in *Pireno* "presumes that the insurance contract in fact will be enforced." 508 U.S. at 504. If the contract is not performed, "there is no risk transfer at all" – which most definitely affects the transfer of risk (to the insured's detriment). *Id.* Indeed, UNUM would not be fighting so hard to be exempted from the notice-prejudice rule if that rule did not affect a transfer of risk. The notice-prejudice rule, like other state laws affecting claims determination and payments, has a direct impact on whether beneficiaries will be paid and thus an immediate effect on whether any risk has been spread.

2. Integral part of the policy relationship. UNUM appears to be arguing that a state law regulating the *administration* of an insurance policy does not affect the insurance *policy* relationship. Pet. Br. 28. This is part of UNUM's broad-ranging effort to limit the ERISA saving clause exclusively to state laws regulating substantive policy benefits. We address this mistaken notion is Part (I)(D), *infra*. Suffice it to say, the saving clause makes no distinction between state insurance laws regulating administration and those regulating benefits, and no decision by this Court has crafted such a dichotomy.

3. Limited to the insurance industry. UNUM's argument as to this factor poses possibly the greatest threat to Congress's intent in enacting the saving clause. According to UNUM, any insurance law that has its genesis in general common law is not a law aimed specifically at the insurance industry and therefore cannot meet the common-sense definition of insurance. Pet. Br. 22-23. Not only does that position mistakenly conflate the

common-sense inquiry with the third *Pireno* factor, it would have the ERISA saving clause save little besides laws dictating policy benefits.

A great many insurance laws have some roots or analogues in the common law, as one would expect. Although insurance contracts pose special concerns that lead to special rules, those rules were rarely created out of whole cloth. Rather, courts and legislators commonly look to existing rules and principles and determine how they should be modified to address the insurance setting. To contend, as UNUM does, that *Pilot Life* compels its position is to contend that *Pilot Life* effectively overturned *Metropolitan Life* because many insurance laws embody principles that may also be found elsewhere in the common law. *Pilot Life*, however, expressly stated that it was not overturning *Metropolitan Life*. 481 U.S. at 57.

C. Applying the Analysis Set Forth in *Metropolitan Life*, the Notice-Prejudice Rule is a Law that "Regulates Insurance" for Purposes of the ERISA Saving Clause

As a matter of common sense, the notice-prejudice rule regulates insurance. The rule governs when insurance policyholders who have filed late notices or submissions of proof have lost their claims. It affects the ultimate issue in any insurance contract – whether the policyholder's claim is paid. If the notice-prejudice rule does not regulate insurance, what does it regulate? Though it might be considered a consumer protection statute – protecting consumers from losing their rights for, as a practical matter, no good reason – the field in which it is operating is the insurance business. Turning to the *National Securities* description, the notice-prejudice rule is both a rule affecting the insurance relationship between Ward and UNUM, as well as a rule affecting the enforcement of an

insurance contract. It is, therefore, plainly a rule addressing the "core of the business of insurance" and, as such, regulates insurance as a matter of common sense.

The *Pireno* factors support that conclusion, for many of the reasons discussed in Part (I)(B), *supra*. The notice-prejudice rule spreads risk because it determines whether the insurance contract will be enforced at all. If the contract is not performed, the insured has not transferred his risk and must, accordingly, bear the full financial brunt of the insured event. As to the second *Pireno* factor, the "performance of an insurance contract . . . is central to the policy relationship between insurer and insured." *Fabe*, 508 U.S. at 503. Unquestionably, the notice-prejudice rule regulates the performance of the insurance contract. Finally, the notice-prejudice rule is confined to entities within the insurance industry. UNUM cites no cases applying the notice-prejudice rule outside the insurance context. That one or two Restatement provisions embody principles similar to the notice-prejudice rule does not change that fact.

Thus, although amici agree with the Ninth Circuit that (1) the notice-prejudice rule regulates insurance as a matter of common sense, (2) the notice-prejudice rule satisfies the second and third *Pireno* factors, and (3) that is enough to establish that the ERISA saving clause applies to the rule, we disagree with one aspect of the Ninth Circuit's holding. The amici states submit that, to the extent the *Pireno* factors are relevant, the notice-prejudice rule also satisfies the first *Pireno* factor.[7]

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[7] If the Court agrees that all three *Pireno* factors are met, it does not have to determine whether they always must be examined and, if so, whether they all *must* be met. We believe, however, that the better course is to answer that question. That is the issue on which certiorari was granted, the lower courts need guidance, and it is an independent ground for affirming the judgment below.

D. Application of the Saving Clause to the Notice-Prejudice Rule Does Not Conflict with the Deemer Clause

UNUM argues that when an insurance company administers an insurance policy for an ERISA plan all state regulation of administration of the policy is direct regulation of the plan barred by the deemer clause. Pet. Br. 37.[8] This argument glosses over the distinction Congress has drawn, for preemption purposes, between insured and self-insured plans. It expands the deemer clause beyond its role of protecting self-insured plans and, correspondingly, eviscerates the insurance saving clause by removing from it a whole body of traditional state insurance law that regulates the insurer's administration of insurance policies. An insurance company is still an insurer for purposes of the saving clause even when it administers an insurance policy sold to an ERISA plan.

UNUM's argument is that if an activity is covered by ERISA, it is not insurance for purposes of the saving clause. An insurer's action granting or denying claims, however, is the core of the business of insurance for it is the mechanism by which the risk transfer is effectuated. Thus, in order to have any meaning at all, insurance laws must include laws that control ERISA covered activities. An ERISA plan's choice to purchase insurance renders the plan subject to state insurance

[8] The deemer clause provides that "neither an employee benefit plan . . . nor any such trust established under such a plan, shall be deemed to be an insurance company or other insurer, bank, trust company, or investment company or to be engaged in the business of insurance or banking for purposes of the law of any State purporting to regulate insurance companies [or] insurance contracts." 29 U.S.C. §1144(b)(2)(B).

laws through the regulation of the insurance company. That is the whole point of the saving clause.[9]

UNUM justifies its extraordinarily broad reading of the deemer clause by reference to congressional concern for plan uniformity. Congress never intended uniformity to be more than a means to an end – to provide protection to employees. Moreover, that concern was addressed by Congress in the enactment of the preemption provision, 29 U.S.C. §1144. By including in that preemption provision a clause saving state laws that regulate insurance, Congress explicitly tempered its concern for plan uniformity to the extent plans choose to become insured. As the Court has previously recognized, "disuniformities . . . are the inevitable result of the congressional decision to 'save' local insurance regulation." *Metropolitan Life*, 471 U.S. at 747.

UNUM draws a distinction between laws regulating insurance benefits (which supposedly can be saved) and laws regulating insurance administration (which supposedly cannot be saved). Nothing in the language or legislative history of ERISA, however, indicates that in structuring the complex express preemption provisions of ERISA, Congress was more

[9] Moreover, the notice-prejudice rule does not even regulate UNUM in its capacity as an ERISA fiduciary. The notice-prejudice rule regulates plan administration by prohibiting insurance companies from inserting into insurance policies a provision that allow claims to be denied as untimely without a showing of prejudice to the insurer. An insurer is not acting as an ERISA plan, or as a plan fiduciary, when it designs the terms of the insurance contracts it sells. When UNUM administers a policy it sells to an ERISA plan, it has a fiduciary duty to administer the policy in accord with its written terms. However, those terms include, as a matter of law, all terms that are mandated or amended by state insurance law. The notice-prejudice rule implicates UNUM's fiduciary duty in this case only because UNUM inserted into the policy a term that is inconsistent with California's insurance law.

concerned with uniform plan administration than uniform benefit structure. Congress's failure to make any distinction between the two in either the saving clause or the deemer clause defeats UNUM's argument. This Court's decisions interpreting the scope of the saving clause and the deemer clause further refute the benefit-administration distinction that UNUM tries to draw.

In *Metropolitan Life*, this Court noted that the language of the deemer clause "makes explicit Congress' intention to include laws that regulate insurance contracts within the scope of the insurance laws preserved by the savings clause." 471 U.S. at 741. No distinction was made between laws that regulate the administrative terms of insurance contracts and laws that regulate benefits to be included in those contracts. While *Metropolitan Life* involved a state mandated-benefit law, *FMC Corp.*, 498 U.S. 52, involved Pennsylvania's anti-subrogation law, a state law affecting plan administration. Citing *Fort Halifax Packing Co. v. Coyne*, 482 U.S. 1 (1987), this Court held that the law related to plans because it interfered with a uniform administrative scheme. *FMC Corp.*, 498 U.S. at 60. However, the law fell within the insurance saving clause because it "directly controls the terms of insurance contracts by invalidating any subrogation provisions they contain." *Id.* at 60-61. The Court then concluded that the deemer clause exempts self-funded, but not insured, plans from state laws regulating insurance. "An insurance company that insures a plan remains an insurer for purposes of state laws 'purporting to regulate insurance' after application of the deemer clause. The insurance company is therefore not relieved from state insurance regulation. The ERISA plan is consequently bound by state insurance regulations insofar as they apply to the plan's insurer." *Id.* at 61. Thus, so long as a state law regulates an insurer, it is excluded from the scope of the deemer clause.

Because the notice-prejudice rule applies to UNUM, the plan's insurer, it falls within the scope of the saving clause, unaffected by the deemer clause.

II. NEITHER THE NOTICE-PREJUDICE RULE NOR THE *ELFSTROM* RULE CONFLICTS WITH ANY SUBSTANTIVE PROVISION OF ERISA

UNUM argues that the notice-prejudice and *Elfstrom* rules are, in any event, preempted by conflict preemption principles because they are in conflict with various substantive provisions of ERISA. Pet. Br. 18; *see Boggs v. Boggs*, 520 U.S. 833, 841 (1997). UNUM makes three conflict preemption arguments. First, that this Court's decision in *Pilot Life* precludes Ward's claim; second, that application of the state laws at issue will conflict with ERISA's provisions by requiring the payment of claims that would not otherwise be "due" under the terms of the insurance policy "as written"; and third, application of the state laws may reverse the insurance company's "claims review" decision to deny benefits. None of these arguments has merit.

1. *Pilot Life*, upon which UNUM principally relies, is readily distinguishable. In *Pilot Life*, an ERISA plan member sought to recover compensatory and punitive damages for failure to pay benefits under the plan through assertion of a state common-law cause of action. This Court found that suit preempted, holding that Congress expressed a clear intent that suits to recover plan benefits must be brought exclusively under federal law; suits under state common law causes of action conflicted with that intent. 481 U.S. at 52-56. Ward's cause of action, by contrast, is for benefits due under his plan – which purchased an insurance policy subject to the notice-prejudice and *Elfstrom* rules. Claims for plan benefits are specifically

provided for in ERISA's civil enforcement scheme. Because Ward's claim is brought under ERISA, not state law, *Pilot Life* is no impediment to such a claim.

UNUM's unduly broad reading of *Pilot Life* effectively abrogates this Court's decision in *Metropolitan Life*. It is true that the success of Ward's suit depends, in part, on whether the insurance contract includes, by virtue of state law, a notice-prejudice provision (or whether the disavowal of an agency relationship contained in the insurance contract may be ignored if the facts show otherwise). In terms of conflict preemption, however, his suit is no different than a suit under ERISA to recover a benefit mandated by state law in a situation where the insurance policy terms omit the benefit or specifically indicate that the benefit is not provided. Both suits are brought under ERISA to recover benefits, but rely, in part, on state laws that modify or contradict the terms of the plan. Even though this Court held in *Metropolitan Life* that state mandated-benefit laws are not preempted by ERISA's express preemption clause, UNUM's reasoning would prevent any attempt to recover mandated benefits from an insurer of an ERISA plan who ignores the law on the theory that the law is in conflict with the plan's terms and the attempt to collect benefits not due under the terms of the plan is in conflict with ERISA's enforcement provisions. *Pilot Life* cannot be read to support such a result.

Finally, ERISA's civil enforcement provision (§502) does not operate to preempt state insurance laws that are saved from preemption by the saving clause, even if the state insurance law creates a remedy or cause of action. In this regard, the states agree with the position of the Solicitor General. *See* U.S. Br. 20-25. This Court has previously noted that "Congress did not intend to pre-empt entirely every state cause of action relating to such [ERISA] plans." *Franchise Tax Bd. v. Construction Laborers Vacation Trust*, 463 U.S. 1, 25 (1983). Laws which

regulate insurance are explicitly saved from preemption. The fact that a state insurance law may also provide a state law cause of action or remedy does not change its basic character as a law that regulates insurance.

2. UNUM further argues that the notice-prejudice rule and the *Elfstrom* rule conflict with ERISA's substantive provisions that require fiduciaries to administer plans "in accordance with" their written terms, and to provide benefits only if they are "due" under those terms. Pet. Br. 20, 32-33; 29 U.S.C. §§ 1104(a)(1)(D), 1132(a)(1)(B). UNUM reasons that application of these state laws will alter contrary terms it inserted into the insurance policy, which in this case constitute the terms of the plan, thereby creating a conflict with these provisions of ERISA. This reasoning allows plans to preempt any state regulation simply by inserting contrary terms in the plan documents. ERISA's requirements that plans be administered according to their written terms and benefits be paid only when due under those terms does not give ERISA plans *carte blanche* to override otherwise applicable law, federal or state. As the Eighth Circuit correctly recognized in *United of Omaha v. Businessmen's Assurance Co. of America*, 104 F.3d 1034, 1041 (8th Cir. 1997), accepting UNUM's position "would be to open the door for insurance companies to avoid any state insurance law simply by including a contrary provision in their group ERISA welfare plans." UNUM's proposed rule would permit ERISA plans and all entities providing services to such plans to evade virtually any state or federal regulation they desired. Congress never intended such a result, and this Court has never approved of such a result.

Adoption of UNUM's argument would render this Court's decisions in *Travelers* and its progeny meaningless Those cases recognize that ERISA operates against a background of traditional state laws that are presumptively not preempted.

Just as a hospital cannot evade state quality control standards by contracting with an ERISA plan to operate under lower standards, an insurance company cannot evade a state insurance regulation by contracting with an ERISA plan to operate in a manner contrary to state insurance laws.[10] Indeed, the application of the state law to the ERISA plan in *Dillingham* would have been preempted by conflict preemption principles were UNUM's position correct. In that case an apprenticeship training agreement, an "employee welfare benefit plan" within the meaning of ERISA, contained a wage scale that conflicted with California's prevailing wage statute. 519 U.S. at 332. Since the plan had not complied with the approval requirements of the prevailing wage law, application of the state law to the plan in that case required the plan to ignore its own plan terms (its wage scale), and pay benefits not due under the plan (the higher wages required under state law).

3. UNUM also claims (Pet. Br. 20, 35) that both the notice-prejudice and the *Elfstrom* rules conflict with the provision of ERISA that requires every employee benefit plan to comply with the benefit claims regulations issued by the Secretary of Labor. UNUM specifically argues that the state law doctrines conflict with those parts of the regulations which provide that a plan's claims procedures may provide for the filing of claims with an insurance company and that "a claim is filed when the requirements of a reasonable claim filing procedure . . . have been met." 29 C.F.R §2560.501-1(c), (d). This argument does not withstand scrutiny; neither the notice-prejudice rule nor the *Elfstrom* rule is in conflict with either of these provisions.

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[10] It may be that, although a state quality control standard does not "relate to" ERISA plans, a particular insurance regulation will "relate to" ERISA plans. But the conflicts preemption analysis is the same. Neither type of law conflicts with ERISA merely because it might conflict with the terms of a particular ERISA plan.

The procedures noted in the regulations are not intended to be exclusive. To the contrary, they specifically provide that they are the *minimum* requirements for employee benefit procedures. 29 C.F.R. §2560.501-1(a). Therefore, state law doctrines that supplement or impose more stringent requirements are not in conflict with the regulation. In *Pilot Life*, this Court found that ERISA's civil enforcement procedures were intended to be exclusive; UNUM's reliance upon *Pilot Life* is therefore misplaced.

The notice-prejudice rule does not conflict with the regulations' definition of when a claim is filed. It simply defines the consequences of untimeliness, whenever the claim is filed. *Elfstrom* does not conflict with that part of the regulation that allows for the filing of claims with an insurance company. It simply allows another party to be considered the agent of the insurance company for filing purposes pursuant to state common law agency principles. Because compliance with these regulations and the state laws at issue is not a "physical impossibility" and the state laws are not "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress," *Gade v. National Solid Wastes Management Ass'n*, 505 U.S. 88, 98 (1992), these laws are not preempted by principles of conflicts preemption.

III. THE *ELFSTROM* RULE DOES NOT "RELATE TO" ERISA PLANS

A. ERISA Does Not Preempt Generally Applicable State Law That Does Not Dictate Or Restrict The Administrative Or Benefit Choices Plans Make

In recent years, this Court has expressly held that ERISA did not alter the starting presumption in preemption cases that

"Congress does not intend to supplant state law." *Travelers*, 514 U.S. at 654; *Dillingham*, 519 U.S. at 331-32; *De Buono*, 520 U.S. at 814. Thus, a party seeking to demonstrate that ERISA preempts a state statute operating in a field "that has been traditionally occupied by the States . . . bear[s] the considerable burden of overcoming" that presumption. *De Buono*, 520 U.S. at 814 (internal quotations omitted). In *Travelers*, this Court concluded that the ERISA preemption analysis must "go beyond the unhelpful text" and "look instead to the objectives of the ERISA statute as a guide to the scope of the state law that Congress understood would survive." 514 U.S. at 656 (internal quotations omitted).

Since its very inception, ERISA's principal object has been to protect plan participants and beneficiaries from employer abuse and mismanagement. H.R. Rep. No. 93-533, at 1 (1973), reprinted in 1974 U.S.C.C.A.N. 4639, 4639; *Boggs*, 520 U.S. at 844. As this Court has stated:

> in enacting ERISA, Congress's primary concern was with the mismanagement of funds accumulated to finance employee benefits and the failure to pay employee benefits from accumulated funds.

Dillingham, 519 U.S. at 326-27 (citing *Massachusetts v. Morash*, 490 U.S. 107, 115 (1989)). Section after section of ERISA either explicitly or implicitly provides protections for employees. 29 U.S.C. §1001(a)-(c). As the United States has argued, "it would be extraordinary if a Congress that was intent on protecting the rights of plan participants and beneficiaries, see 29 U.S.C. 1001, in fact deprived those parties of the protection of traditional state regulation merely because the services ordinarily subject to that regulation were provided by ERISA plans." Brief for the United States as Amicus Curiae Supporting Petitioners, *De Buono v. NYSA-ILA Medical and Clinical Services Fund* at 20 (November 1996).

In *Dillingham* the Court set out the two-pronged "relate to" analysis as follows: First, a law which makes reference to an ERISA plan is preempted. "Where a State's law acts immediately and exclusively upon ERISA plans, as in *Mackey*, or where the existence of ERISA plans is essential to the law's operation, as in *Greater Washington Bd. of Trade* and *Ingersoll-Rand*, that 'reference' will result in preemption." 519 U.S. at 325.

Second, state laws which have a connection to ERISA plans are preempted. To determine whether a law has a connection to an ERISA plan, this Court looks both to ERISA's objectives as a guide to the scope of the state law that Congress understood would survive, and to the nature of the law's effect on ERISA plans. *Travelers*, 514 U.S. at 656; *Dillingham*, 519 U.S. at 325. Even assuming the basic purpose of ERISA's preemption clause is to "avoid a multiplicity of regulations in order to permit nationally uniform administration of employee benefit plans," *Travelers*, 514 U.S. at 657, a state law does not have a prohibited connection to plans if it "does not bind plan administrators to any particular choices," does not function as a regulation of the plan itself or interfere with uniform plan administration. *Id.* at 659. Thus, a state law of general application in an area of traditional state regulation that only influences plan administrative or benefit choices, *Travelers*, 514 U.S. at 662, merely imposes some burdens on the administration of ERISA plans, *De Buono*, 520 U.S. at 815, or simply "alters the incentives" without "dictat[ing] the choices facing ERISA plans" does not relate to plans within the meaning of the statute. *Dillingham*, 519 U.S. at 334. This new paradigm not only reflects a respect for traditional state powers, but also countenances a significant cabining of ERISA's preemptive effect.

This Court has recognized a wide range of state laws of general application, within the states' traditional authority, that are not preempted even though they may have some effect upon ERISA plans. For example, state health laws, tort laws, consumer protection laws, tax laws, and medical practice laws all have an effect on ERISA plans. Each is a traditional state responsibility and each represents concerns that extend well beyond ERISA issues. Congress could never have intended to preempt such laws.

B. The *Elfstrom* Rule Does Not "Relate to" ERISA Plans Because it Does Not Dictate or Restrict the Administrative Choices that an ERISA Plan Makes

The *Elfstrom* rule does not relate to ERISA plans. *Elfstrom* is merely the straightforward application of ordinary state common law agency principles to insurance companies. In fact, it is probably a misnomer to refer to the agency rule at issue as the "*Elfstrom* rule." The rule whose preemption is being reviewed is simply ordinary agency law; the expression "*Elfstrom* rule" was merely used by the Ninth Circuit as a shorthand expression for that agency law. (For convenience, we will also use that expression.) *Elfstrom* defines the legal consequences to insurance companies of involving others in policy administration by defining an agency relationship between them and other parties with whom they may do business. Because some ERISA plans purchase insurance, *Elfstrom* may have an indirect impact on those plans. *Elfstrom* may influence either the options available to ERISA plans in the insurance marketplace or the choices ERISA plans make

among those options.[11] However, it does not dictate or restrict the substantive or administrative choices ERISA plans make or impose any obligations upon plans. The *Elfstrom* rule is, therefore, one of many common laws regulating insurance company conduct that "do not 'relate to' benefit plans in the first instance." *Metropolitan Life*, 471 U.S. at 741.

Elfstrom does not refer to or depend upon the existence of ERISA plans. It applies to the relationship between insurers and any other party who may assist in policy administration. *See McCormick v. Sentinel Life Ins. Co.*, 153 Cal. App. 3d 1030, 200 Cal. Rptr. 732 (1984) (applying *Elfstrom* to the relationship between an insurer and a credit union). Because the *Elfstrom* rule is indifferent to the identity of the other party whom insurance companies may involve in policy administration and the other party's relationship, if any, to ERISA plans, the law makes no reference to plans. *See Dillingham*, 519 U.S. at 325.

Nor does the *Elfstrom* rule have a connection to plans even when, as in this case, it applies to the relationship between an insurance plan and an employer who purchased the insurance policy that funds the ERISA plan. *Eflstrom* applies generally applicable common law agency principles to insurance companies. Agency law is not an area with which ERISA is concerned. It is not part of a plan's administrative scheme such as a claims determination or benefits disbursement procedure.

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[11] As the California Supreme Court recognized in *Elfstrom*, the involvement of other parties in insurance policy administration is generally motivated by economic concerns, specifically reduced premium costs, that are advantageous to both the insurer and the policyholder. *Elfstrom v. New York Life Ins. Co.*, 67 Cal.2d 503, 509 (1967). These economic benefits may well be affected by the *Elfstrom* rule, resulting in insurance companies limiting the options they give policyholders to become involved in administration, or affecting the costs of those options.

See Fort Halifax Packing Co., 482 U.S. at 9. It is rather one of the "myriad state laws in areas traditionally subject to local regulation." *Travelers,* 514 U.S. at 668.

Elfstrom does not have a direct impact upon plans. It does not compel ERISA plans or plan sponsors to involve themselves in policy administration, nor does it prohibit such a choice. It does not impose any additional obligations upon employers who choose to become involved in policy administration. Unlike a mandated benefits law, which compels insured plans to "purchase the . . . benefits specified in the statute when they purchased a certain kind of common insurance policy," *Metropolitan Life*, 471 U.S. at 739, *Elfstrom* does not even indirectly dictate or restrict an ERISA plan's conduct. It does not tell insurers how to structure policies or policy administration. Nor does it dictate or restrict an insurance company's choices concerning who may be involved in the administration of insurance policies. Because *Elfstrom* does not mandate either an insurer's or an ERISA plan's choices concerning plan administration or benefit structure, it does not impede the uniform inter-state operation of plans. Assuming such options are available in the insurance marketplace, a plan which operates in numerous states may make uniform choices as to what parties will be involved in the administration of insurance policies it purchases. Application of the *Elfstrom* rule in this case will not require the plan or the employer to do anything differently in the future or to vary its conduct from state to state.

While *Elfstrom* does not impose legal obligations on insurers or plans, it does result in the imposition of legal consequences upon insurance companies who choose to involve others in the administration of the insurance policies they sell. By charging insurers with knowledge of those who are determined to be their agents, *Elfstrom* renders insurers

liable for the conduct of their agents. By charging UNUM, the insurer, with knowledge of MAC, the employer (assuming the facts establish an agency relationship under *Elfstrom*), UNUM may have to pay a claim it would have otherwise denied as untimely. However, that consequence is not imposed upon UNUM in its capacity as an ERISA fiduciary, but as an insurance company engaged in the business of insurance. Because the plan sponsor transferred the plan's risk of loss by insuring the plan, payment of that claim has no direct impact upon the plan. If UNUM has to pay more claims because of *Elfstrom,* it may raise its premiums in certain states. If it decides to supervise the entities who are involved in policy administration more closely, this may increase premiums. However, all kinds of non-preempted state laws that apply to insurance companies have a similar indirect economic impact upon plans.

To be sure, the indirect economic impact of *Elfstrom* may influence plan administrative choices. But a state law does not relate to plans simply because it imposes consequences on certain plan choices and therefore alters the incentives for plan choice. In *Dillingham,* this Court had little difficulty concluding that, because a statute merely altered the incentives facing ERISA plans, it did not "relate to" such plans. This was with full recognition that the incentives resulted from the consequences the state law imposed on certain choices: "The statute does not bind the plan to anything . . . . If a contractor chooses to hire apprentices for a public works project, it need not hire them from an approved program (*although if it does, it must pay those apprentices journeymen wages*)." *Dillingham*, 519 U.S. at 332 (emphasis added). Similarly, *Elfstrom* does not bind insurers, and therefore plans that buy insurance policies, to any particular administrative choice. However, if an insurer chooses to involve other parties in

policy administration, it will be charged with the knowledge of those who are determined to be its agents.

Nor, finally, does the *Elfstrom* rule "relate to" the ERISA plan because UNUM chose to include in the insurance policy terms that attempt to override it. Plans cannot avoid a state law by including terms in their employee benefit plan that contradict those laws. As discussed in Part II above, *Dillingham* could not have come out as it did if state law were preempted when the terms of an ERISA plan conflict with the law. Since the *Elfstrom* rule is a traditional state law that defines an agency relationship between an insurance company and other parties, and does not dictate or restrict plan structure, it has too tenuous an impact on plans to have a connection to them within the meaning of ERISA.[12]

CONCLUSION

For the foregoing reasons, the decision below should be affirmed.

[12] If, however, this Court concludes that *Elfstrom* does relate to plans, the states agree with the position of the United States that the case should be remanded to the Ninth Circuit to consider whether *Elfstrom* should be adopted as a rule of federal common law. U.S. Br. 28.

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